



Lloyd's Certificate

This Insurance is effected with certain Underwriters at Lloyd's, London.

This Certificate is issued in accordance with the limited authorization granted to the Correspondent by certain Underwriters at Lloyd's, London whose syndicate numbers and the proportions underwritten by them can be ascertained from the office of the said Correspondent (such Underwriters being hereinafter called "Underwriters") and in consideration of the premium specified herein, Underwriters hereby bind themselves severally and not jointly, each for his own part and not one for another, their Executors and Administrators.

The Assured is requested to read this Certificate, and if it is not correct, return it immediately to the Correspondent for appropriate alteration.

All inquiries regarding this Certificate should be addressed to the following Correspondent:

Clements International
One Thomas Circle, NW 8th floor
Washington, DC 20005

Telephone: 1.800.872.0067 or 1.202.872.0060

Fax: 1.202.466.9064

www.clements.com

SLC-3 (USA) NMA 2868 (24/08/2000)

Form approved by Lloyd's Underwriters' Non-Marine Association Limited

CERTIFICATE PROVISIONS

- 1. Signature Required.** This Certificate shall not be valid unless signed by the Correspondent on the attached Declaration Page.
- 2. Correspondent Not Insurer.** The Correspondent is not an Insurer hereunder and neither is nor shall be liable for any loss or claim whatsoever. The Insurers hereunder are those Underwriters at Lloyd's, London whose syndicate numbers can be ascertained as hereinbefore set forth. As used in this Certificate "Underwriters" shall be deemed to include incorporated as well as unincorporated persons or entities that are Underwriters at Lloyd's, London.
- 3. Assignment.** This Certificate shall not be assigned either in whole or in part without the written consent of the Correspondent endorsed hereon.
- 4. Attached Conditions Incorporated.** This Certificate is made and accepted subject to all the provisions, conditions and warranties set forth herein, attached or endorsed, all of which are to be considered as incorporated herein.

**This Declaration Page is attached to and forms part of the Certificate provisions
(Form SLC_3 USA NMA 2868)**

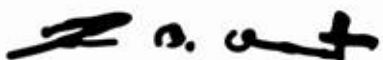
Certain Underwriters at Lloyd's, London
Will pay benefits according to the conditions of this Certificate

SCHOLARS' HEALTH INSURANCE PLAN

Employer Name: Korea International School
Employer Address: 373-6 Baekhyun-dong, Bundang-gu, Sung-nam city, Korea
Group Number: 4832
Effective Date: August 1, 2010
Expiration Date: July 31, 2011
(Both days at 12: 01a.m. Standard time)
Premium Due Date: 1st of Each Month

This Certificate is issued in consideration of the application of the *Employer*, a copy of which is attached to and made part of this Certificate, and any individual and *Dependent* applications, and of the payment by the *Employer* of premiums as required.

Signed for the Company



Agreement Number: 330306 2008

THIS A NON-PARTICIPATING GROUP PLAN

LLOYD'S

One Lime Street London EC3M 7HA



CERTIFICATE OF INSURANCE

TABLE OF CONTENTS

A. Agreement	3
B. Schedule of Benefits - Health Insurance	5
C. Pre-Certification and Benefits Management Program	9
D. Definitions Applicable to Health Insurance	11
E. Eligibility for Insurance	20
F. Health Insurance Benefits - Descriptions	26
G. General Exclusions	33
H. Extension of Medical Benefits	37
J. Coordination of Medical Benefits	37
K. General Provisions	41

A. AGREEMENT

Certain Underwriters at Lloyd's (the Underwriters) on the behalf of Clements & Underwriters, Inc. DBA Clements International promises to provide the Insured Person with the benefits described in this Master Certificate of Insurance. The Underwriters makes this promise in consideration of the Assureds' Application, the Insured Person's Application and payment of Premium.

The Underwriters hereby recognizes Clements International as the Plan Administrator. All communications, notices and payments required under this Agreement shall be transmitted through the Plan Administrator. The Underwriters shall consider receipt by the Plan Administrator receipt by the Underwriters.

This Master Certificate of Insurance is effective as of August 1, 2010 and shall remain in effect until terminated in accordance with Section K. GENERAL PROVISIONS, article 18. TERMINATION OF CERTIFICATE OF INSURANCE.

The Underwriters' agreement is subject to all terms, conditions, provisions and exclusions of this Master Certificate of Insurance, including any Exhibits, Schedules, Endorsements, and/or Riders attached thereto.

B. SCHEDULE OF HEALTH INSURANCE BENEFITS

This schedule of Health Insurance Benefits is a brief outline of the Benefits payable under this *Certificate of Insurance*, subject to its definitions, conditions, limitations, exceptions, exclusions, and other provisions.

Benefits for *Covered Medical Expenses* will be payable as described in this Schedule of Benefits (Section B) and Health Insurance Benefits - Descriptions (Section F) in the *Certificate of Insurance* and in any amendments or endorsements to this *Certificate of Insurance*, subject to all provisions of this *Certificate of Insurance*, and when the requirements of *Pre-Certification and Benefits Management* are followed.

If a *Covered Person* does not comply with the *Certificate of Insurance's Pre-Certification and Patient Care Management* program, certain benefits under this *Certificate of Insurance* may be reduced. Details concerning the *Pre-Certification and Patient Care Management* program, including possible Effects on Benefits for non-compliance with the program, are found in Section

Schedule of Benefits - Part I

International Plan

The benefits of those *Covered Persons* enrolled in the International Plan are as follows:

B.1. Maximum Benefit \$5,000,000 Lifetime per Covered Person

B.2. Deductible \$250 per Covered Person, per policy year outside of the US and in network in the US.

\$500 per Covered Person, per policy year out of network in the US

3 times the individual *Deductible* per *Family*, per policy year

Common Accident: If two or more *Covered Persons* are injured in the same accident and incur *Covered Expenses* for those injuries in the policy year in which the accident occurs, not more than one *Deductible* will be deducted from the total *Covered Expenses* incurred for them during the rest of that policy year.

B.3. Percentage of Covered Expenses Payable

100% of Reasonable and Customary charges incurred outside the United States, US territories and possessions, except for expenses to which specific limitations apply.

100% of Reasonable and Customary charges incurred within the Preferred Provider Network in the United States, US territories and possessions, and

80% of Reasonable and Customary charges for Covered Expenses (up to the Out-of-Pocket Limit) incurred outside the Preferred Provider Network within United States, US territories and possessions, and

100% of the balance of Reasonable and Customary charges for Covered Expenses incurred within the United States, US territories and possessions which exceed the Out-of-Pocket Limit for the remainder of the policy year. This provision does not include expenses to which specific limitations apply.

B.4. Out-of-Pocket Limit \$0 Per Covered Person, per policy year if in network in the US.
\$5,000 Per Covered Person, per policy year if out of network in the US.
3 Times the individual *Out of Pocket Limit* per *Family*, per policy year

B.5. Exceptions to the Amounts Payable With Respect to Certain Benefits:

Hospital Emergency Room in the United States, US Territories and Possessions and Canada

\$50 Co-Payment per visit, if not admitted as an in patient.

100% of Reasonable and Customary Covered Expenses within 72 hours of Injury or Medical Emergency (no Deductible)

80% of Reasonable and Customary Covered Expenses after 72 hours of Injury or Medical Emergency (after Deductible)

Chiropractic Care

\$30 *Maximum Benefit* per visit, after the initial visit, for all services provided during the visit, including manipulation of bones, joints and soft tissue (limited to one visit in any one day)

\$1,000 *Maximum Benefit* per policy year

Rehabilitative Therapy

20 Visits maximum per policy year

Hospice (U.S. only)	80% Benefits Payable after Deductible, 180 days of care maximum.
Family Counseling	\$500 <i>Maximum Benefit</i> while covered under the <i>Certificate of Insurance</i> .
Bereavement Counseling	\$100 for family members, but not beyond 6 months from the <i>Covered Person's</i> death
Home Health Care	2 visits per day maximum (4 hours of Home Health Care services are the equivalent of 1 visit) 90 visits maximum per policy year
Private Duty Nursing (outside U.S. only) Inpatient and Outpatient:	8 Hours maximum per day 30 Days maximum per policy year
Outpatient Skilled Nursing Care (in U.S. only)	2 Hours maximum per day 50 Visits maximum per policy year
Transplant Expense	\$1,000,000 per Covered Person
Emergency Medical Transportation Benefits	
Local Emergency Transportation	100% Reasonable & Customary
Emergency Reunion	As described in Section F1
Maximum Transportation to Residence in Country of Assignment	\$10,000
Maximum Repatriation of Bodily Remains	\$10,000
Total Maximum Benefit	\$25,000
Remote Medical Transportation	100% Reasonable & Customary
Annual Physical Examination (wellness benefit)	
	100% of Reasonable and Customary Charges (no deductible)
	100% of Reasonable and Customary Charges for Necessary immunizations
	1 (One) examination per policy year
	\$400 per policy year
Physical Examinations for Newborns	
	100% of Reasonable and Customary Charges (no deductible)
	Maximum of 6 within the first year of life
	100% Reasonable and Customary Charges for necessary diagnostic testing and immunizations
Out-patient prescription drugs	
	\$5 co-payment per 30 day prescription outside of the US
	\$5 co-payment per 30 day generic prescription in the US
	\$15 co-payment per 30 day brand name prescription in the US
	100% of all Covered Expenses after applying the co-payment
	100% of the delivery cost is provided under the Mail-order Prescription Drug Program (Customs charges may apply and are the responsibility of the insured person)

Schedule of Benefits - Part II

Custom Plan

The benefits of those *Covered Persons* enrolled in the *Custom Plan* are as follows.

B.6. Maximum Benefit

\$5,000,000 Lifetime per *Covered Person*, outside the United States, US Territories and Possessions and Canada

\$150,000 per lifetime per *Covered Person*, inside the United States, US Territories and Possessions and Canada, including *incidental emergencies* only

B.7. Deductible

\$250 per *Covered Person*, per policy year

\$500 per *Covered Person*, per policy year out of network in the US

3 times the individual *Deductible* per *Family*, per policy year

Common Accident: If two or more *Covered Persons* are injured in the same accident and incur *Covered Expenses* for those injuries in the policy year in which the accident occurs, not more than one *Deductible* will be deducted from the total *Covered Expenses* incurred for them during the rest of that policy year.

B.8. Percentage of Covered Expenses Payable

100% of Reasonable and Customary charges incurred outside the United States, US Territories and Possessions, except for expenses to which specific limitations apply

100% of Reasonable and Customary charges incurred within the Preferred Provider Network in the United States, US Territories and Possessions, and

80% of Reasonable and Customary charges for *Covered Expenses* (up to the Out-of-Pocket Limit) incurred outside the Preferred Provider Network within the United States, US Territories and Possessions, and

100% of the balance of Reasonable and Customary charges for *Covered Expenses* incurred within the United States, US Territories and Possessions which exceed the Out-of-Pocket Limit for the remainder of the policy year. This provision does not include expenses to which specific limitations apply.

B.8.1. Additional Conditions and Definition applicable to the *Custom Plan* benefits

Additional Benefit Limitation applicable to *Covered Expenses* incurred in the United States (including Puerto Rico) and Canada –

Benefits will be payable for *Covered Expenses* incurred in these countries, but only for *incidental emergencies* that occur only while taking a *trip* to these countries for reasons other than to secure medical attention.

Additional Definitions applicable to *Custom* benefits –

For the purposes of this *Certificate of Insurance*, *incidental emergency* means the occurrence of an *accident* or the sudden and unforeseen onset of an *illness* for which neither causes nor conditions existed before the trip.

For the purposes of this *Certificate of Insurance*, *trip* means a visit of sort duration and the total number of days accumulated on *trips* in any 12 month period shall not exceed thirty (30) days.

Eligibility –

Persons who are otherwise eligible, but are citizens of the United States, US Territories and Possessions and Canada, are not eligible to be enrolled for *Custom* benefits.

Additional Exclusion –

Benefits will not be payable for either *pre-existing conditions* or the aggravation of existing conditions while in the United States, US Territories and Possessions and Canada.

C. PRECERTIFICATION SERVICES PATIENT CARE MANAGEMENT

A *Covered Person* must follow the *Pre-Certification and Patient Care Management* Program in order to be entitled to receive full benefits under this *Certificate of Insurance*.

Review services incorporate precertification, concurrent, and retrospective review of care, as well as discharge planning services.

Inpatient Care

- Hospital Inpatient Admissions
- All inpatient surgery and procedures
- Psychiatric and Substance Abuse Inpatient and Partial Admissions
- Rehabilitation Admissions
- Skilled Nursing Facility Admissions

Ancillary Services

- Hospice
- Home Health Care
- Home Infusion
- Private Duty Nursing
- Non-Emergency Ambulance

Transplant Services

Notification of transplant services must be provided as soon as the need for an organ or tissue transplant is known.

Maternity Care

Notification of Maternity Care should be provided as soon as the pregnancy is known.

Outpatient Surgical Procedures

The following surgeries and procedures require precertification regardless of where preformed (unless otherwise noted):

- Any potential cosmetic or reconstructive procedure (see potential cosmetic / reconstructive procedure listing)
- Arthroplasty
- Arthroscopy, diagnostic and surgical (includes arthroscopic knee surgery)
- Bariatric procedures and surgery including gastric bypass
- Bunionectomy
- Carpal tunnel release
- Cholecystectomy, laparoscopic
- Hernia repair (ventral and abdominal) (not inguinal)
- Hip, total

- Hysterectomy
- Knee, total
- Pain management services that include injections and blocks: epidural, facet, and/or trigger point
- Penile prosthesis insertion
- Sinus surgery
- Spinal/ vertebral surgery
- Temporomandibular joint surgery
- Treatment of medical complications of cosmetic surgery
- Uvulopalatopharyngoplasty (uppp)
- Wisdom teeth removal/oral surgery performed in Short Procedure Unit (SUP)*

Diagnostic procedures

- PET scans
- Sleep Studies

Therapy, Restorative, and DME Services

- Cardiac Rehabilitation
- Pulmonary rehabilitation
- Prosthesis/ Orthotics
- Durable Medical Equipment over \$250.00
- Physical Therapy, Occupational Therapy, Chiropractic Therapy

C.1. Effect on Benefits

If a *Covered Person* does not follow the *Pre-Certification and Patient Care Management* Program as detailed above, the benefit percentage payable for *Covered Medical Expenses* incurred for all treatment, services, and supplies related to the claim may, solely at the option of the Underwriters, be reduced to and payable at 60% of the first \$100,000 of *Reasonable and Customary Charges* and 40% of the balance of *Reasonable and Customary Charges* (whether or not the *Out-of-Pocket Limit* has been met), after any *Deductible* amount which may apply.

The reduction in the benefit percentage will not be applied where there is no *Participating Provider Network* in the city or immediate vicinity where the *Covered Person* is to be treated, provided the *Covered Person* complied with the notification requirements.

Medical transportation beyond the use of local emergency ambulance transportation will not be considered a *Covered Expense* unless the Underwriters *Medical Coordinator* arranges transportation or agrees to such transportation.

The additional amounts a *Covered Person* is required to pay as a result of the lower percentage payable due to not following this *Pre-Certification and Benefits Management* Program will not be used to satisfy any *Deductible* amount or the *Out-of-Pocket Limits* in the *Certificate of Insurance*.

C.2. Certification does not Guarantee Benefits

Benefits payable under the *Certificate of Insurance* are still subject to eligibility at the time *Charges* are actually incurred, and to all other terms, limitations, and exclusions of the *Certificate of Insurance*. *Certification* does not guarantee or confirm benefits under the *Certificate of Insurance*.

D. DEFINITIONS APPLICABLE TO HEALTH INSURANCE

Certain words and phrases used in this *Certificate of Insurance* are defined below. Other words and phrases may be defined where they are used:

Active, full-time employee means an employee who works at least 21 hours per week for a school. Eligible Employees must have defined job descriptions for which they can, upon request from the Underwriters, provide proof of such. The Underwriters has, at any time, the right to request medical evaluation to determine the eligible employee's capacity to fulfill his or her work related duties. Expenses incurred in relation with the medical evaluation are the Underwriters' responsibility.

Ambulatory Surgical Center means a facility which:

1. has as its primary purpose to provide elective surgical care; and
2. admits and discharges a patient within the same working day; and
3. is not part of a *Hospital*.

"*Ambulatory Surgical Center*" does not include:

1. any facility whose primary purpose is the termination of pregnancy;
2. an office maintained by a *Physician* for the practice of medicine; or
3. an office maintained by a *Dentist* for the practice of *Dentistry*.

Birth Center means a facility which:

is mainly a place for the delivery of a child or children at the end of a normal pregnancy; and meets one or both of the following tests:

it is licensed as a *Birth Center* under the laws of the jurisdiction where it is located; and/or

it meets all the following requirements:

- a. it is operated in accordance with the laws of the jurisdiction where it is located;
- b. it is equipped to perform all necessary routine diagnostic and laboratory tests;
- c. it has trained staff and equipment required to properly treat potential emergencies of the mother and of the child;
- d. it is operated under the full-time supervision of the Physician or a Registered Nurse (R.N.);
- e. it has at all times a written agreement with at least one Hospital in the area for immediate acceptance of a patient in the event of a complication;
- f. it maintains medical records for each patient; and
- g. it is expected to discharge or transfer each patient within 24 hours after the delivery.

Certification, Certify and Certified mean that the Underwriters, following notification of a course of treatment requiring notification, has acknowledged the course of treatment, provided the *Covered Person* with the names and addresses of members of the *Participating Provider Network* (if applicable), to which the *Covered Person* may have access as a *Covered Person* under the *Certificate of Insurance*, and confirmed that such treatment is *medically necessary*.

These terms also mean that the Underwriters have received notification in accordance with the requirements of Section C.

Complications of Pregnancy means:

1. when pregnancy is not terminated, conditions that require Hospital Confinement, whose diagnoses are distinct from pregnancy but are adversely affected by or are caused by pregnancy, such as:
 - a. acute nephritis
 - b. nephrosis
 - c. Cardiac decompensation
 - d. missed abortion, and
2. when pregnancy is terminated:
 - a. non-elective cesarean section
 - b. Ectopic pregnancy that is terminated, or
 - c. Spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy will not include false labor; occasional spotting; *Physician* prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy that do not constitute a nosologically distinct complication of pregnancy.

Confinement means admission to a facility as a registered inpatient. Two or more periods of *Confinement* will be deemed one period of *Confinement* unless discharge from and readmission to the facility are separated by at least 60 days.

Covered Expenses means the *Reasonable and Customary Charges* incurred by a *Covered Person*, while covered under this *Certificate of Insurance*, for *medically necessary* services, treatments or supplies described under the provisions titled Covered Medical Expenses and, if applicable, Covered Dental or Vision Care Expenses.

Covered Person means an *Employee* or his or her *Dependent* who has enrolled for and is entitled to coverage under this *Certificate of Insurance* and for whom the required premium has been paid.

Covered Transplant means a transplant involving the heart, heart/lung, lung, kidney, kidney/pancreas, liver and allogenic and autologous bone marrow.

Custodial Care means treatment or services which could be rendered safely and reasonably by a person not medically skilled, regardless of who recommends them and where they are provided, and which are designed mainly to help the patient with daily living activities. Such activities include but are not limited to:

help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising;
dressing
preparing meals or special diets
moving the patient
acting as a companion or sitter; and

supervising medication which can usually be self-administered.

Custodial Care includes:

1. the provision of room and board, nursing care, or such other care which is provided to an individual who is mentally or physically disabled and who, as determined by the individual's attending Physician, has reached the maximum level of recovery;
2. in the case of an institutionalized person, room and board, nursing care or such other care which is provided to an individual for whom it cannot reasonably be expected that medical or surgical treatment will enable him or her to live outside an institution; and
3. rest cures, respite care and home care provided by family members.

Upon receipt and review of a claim, the Underwriters or an independent medical review will determine if a service or treatment is *Custodial Care*.

Deductible means the dollar amount of *Covered Expenses* for which a *Covered Person* is responsible to pay before benefits are payable under this *Certificate of Insurance*. Such amount will not be reimbursed under the *Certificate of Insurance*. After the *Deductible* amount has been paid by the *Covered Person*, benefits for *Covered Expenses* will be payable under this *Certificate of Insurance* at the percentage rate shown on the Schedule of Benefits.

Durable Medical Equipment means equipment that is:

medically necessary

1. made for and mainly used in the treatment of an *Injury* or an *Illness*
2. not useful in the absence of an *Illness* or *Injury*
3. made to withstand repeated use over an extended period of time
4. suited for use in the home, and
5. used to improve a permanent medical condition.
6. **insulin pumps; glucometers**

Durable Medical Equipment does not include:

1. motor driven wheelchairs or beds;
2. comfort items such as telephone arms and over bed tables;
3. items used to alter air quality or temperature such as air conditioners, humidifiers, dehumidifiers, and purifiers (air cleaners);
4. disposable supplies;
5. exercycles, More wheels,
6. sun or heat lamps, heating pads,
7. bidets, toilet seats, bathtub seats, sauna baths, whirlpool baths
8. elevators, exercise equipment; and similar items.

Emergency Confinement means a *Hospital confinement* required as the result of a serious *Injury* or the onset of a life-threatening condition that requires immediate medical or surgical care to prevent loss of life

or permanent damage to the organs or systems of the body. Examples of such injuries or conditions include, but are not limited to heart attack, stroke, poisoning, loss of breath, severe bleeding, loss of consciousness, convulsions and severe trauma.

Emergency Medical Transportation is either:

Local which means transportation to the hospital or clinic nearest the Covered Person's residence or the place of the Injury or onset of the Illness, or

Remote means further away than a local facility. *Remote Medical Transportation* must be arranged by the Underwriters *Medical Coordinator* to be a *Covered Expense*.

Employee means a person who is actively at work with the *Employer* on a full time basis, or who is an owner, partner or agent of the *Employer*.

Employer means the entity which:

1. has applied for coverage and is named as the *Employer*, on the face page of this *Certificate of Insurance*; and
2. is providing a group insurance plan for its insured *Employees* under this *Certificate of Insurance*.

EXPERIMENTAL/INVESTIGATIONAL - a drug, biological product, device, medical treatment or procedure which meets any of the following criteria:

1. Is the subject of ongoing Phase I or Phase II Clinical Trials;
2. Is the research, experimental, study or investigational arm of on-going Phase III Clinical Trials or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis;
3. Is not of proven benefit for the particular diagnosis or treatment of the Covered Person's particular condition;
4. Is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence, as effective and appropriate for the particular diagnosis or treatment of the Covered Person's particular condition; or
5. Is generally recognized by either Reliable Evidence or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of the Covered Person's particular condition, is recommended.

A drug will not be considered experimental/ investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational New Drug Exemption (as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia recognize the usage as appropriate medical treatment:

1. The American Hospital Formulary Service Drug Information; or
2. The United States Pharmacopoeia Drug Information

In any event, any drug which the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered experimental/ investigational.

Any biological product, device, medical treatment or procedure is not considered experimental/ investigational if it meets all of the criteria listed below in paragraphs A-E:

- a. Reliable Evidence exists that the biological product, device, medical treatment or procedure has a definite positive effect on health outcomes.
- b. Reliable Evidence exists that over time the biological product, device, medical treatment or procedure leads to improvement in health outcomes; i.e., the beneficial effects outweigh any harmful effects.
- c. Reliable Evidence clearly demonstrates that the biological product, device, medical treatment or procedure is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.
- d. Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above in paragraph C, is possible in standard conditions of medical practice, outside clinical investigative settings.

Expatriate means an individual who resides and is employed in a country other than the United States, US territories and possessions, or Canada, and of which he or she is not a citizen.

Extended Care Facility means an institution that meets all of the following requirements:

1. it must be operated pursuant to law;
2. for U.S. facilities, it must be approved for payment of Medicare benefits or be qualified to receive such approval if requested;
3. it must be primarily engaged in providing, in addition to room and board accommodations, skilled nursing services under a licensed Physician's supervision;
4. registered or licensed practical nurses must supervise 24-hours-a-day; and
5. a daily record for each patient must be maintained.

Extended Care Facility does not include any institution that is primarily a clinic; a rest home; a home for the aged; a place for alcoholics or drug addicts; a place for *Custodial Care*; or a facility for mental *Illness*.

Home Health Care Agency means an agency or organization, or subdivision thereof, which:

1. is primarily engaged in providing skilled nursing services and other therapeutic services in the *Covered Person's* home;
2. is duly licensed, if required, by the appropriate licensing facility;
3. has policies established by a professional group associated with the agency or organization, including at least one Physician and one registered graduate nurse (R.N.), to govern the services provided;

4. provides for full-time supervision of such services by a Physician or by a Registered Nurse (R.N.);
5. maintains a complete medical record on each patient; and
6. has a full-time administrator.

Home Health Care Plan means a program:

1. for the care and treatment of the Covered Person in his or her home;
2. established and approved in writing by his or her attending Physician; and
3. Certified, by the attending Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or in an Extended Care Facility.

Hospice means an agency which provides a coordinated plan of home and inpatient care to a terminally ill person and which meets all of the following tests:

1. has obtained any required state or governmental license or Certificate of Need;
2. provides service 24--hours-a-day, 7 days a week;
3. is under the direct supervision of a Physician;
4. has a nurse coordinator who is a Registered Nurse (R.N.);
5. has a duly licensed social service coordinator;
6. has as its primary purpose the provision of Hospice services;
7. has a full-time administrator; and
8. maintains written records of services provided to the patient.

Hospital means an institution which is licensed as a *Hospital* under the laws of the jurisdiction where it is located, and:

1. is primarily engaged in providing, for pay and on its own premises, inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities
2. is under the direction of a staff of Physicians, and
3. provides 24-hour nursing service rendered or supervised by a registered graduate nurse
4. has facilities on its premises for major surgery (or a written contractual agreement with an accredited Hospital for the performance of surgery) and for U.S. facilities,
5. is accredited by the Joint Commission on Accreditation of Health Care Facilities.

"Hospital" does **not** include:

1. a facility, or part thereof, which is principally used as: a rest or *Custodial Care* facility
2. nursing facility; convalescent facility;

Extended Care Facility, or facility for the aged or for the care and treatment of drug addicts or alcoholics, unless specifically provided in this *Certificate of Insurance* and/or as mandated by local law, or any institution in which the *Covered Person* receives treatment for which he or she is not required to pay.

Illness means:

1. a bodily disorder or infirmity
2. *Complications of Pregnancy*; and
3. a pregnancy, for an *Employee* or his or her *Spouse* covered under this *Certificate of Insurance*.

Injury means a bodily *Injury* that is:

1. sustained by a *Covered Person* while insured under this *Certificate of Insurance*; and
2. caused by an Accident directly and independently of all other causes.

A *Covered Person* must begin receiving services, supplies or treatment within 72 hours from the time of accident in order for it to be considered an *Injury*. All injuries sustained by one person in any one accident, including all related conditions and recurrent symptoms of these injuries, are considered a single *Injury*.

Local National means an individual who is employed in the country of which he or she is a citizen.

Medical Emergency means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result:

1. in placing the patient's body in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

Medically necessary means that a treatment, service, supply, drug or *Hospital* or *Extended Care Facility Confinement* (or part of a *Confinement*):

1. is appropriate and essential to diagnose or treat the patient's Illness or Injury;
2. does not exceed, in scope, duration, or intensity, the level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment;
3. is prescribed by a Physician;
4. is consistent with widely accepted professional standards of medical practice in the jurisdiction where treatment is rendered;
5. is not primarily for the personal comfort or convenience of the patient, the family, Physician, or other provider of care;
6. is not a part of or associated with the scholastic education or vocational training of the patient;
7. is not Experimental or Investigative; and
8. in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a *Physician* has prescribed, recommended, approved or provided a treatment, service, supply, or *Confinement* does not, in itself, make it *medically necessary*. The Underwriters have the right to examine all conditions listed above in reviewing a claim for treatment, service, supply, drug or *Hospital* or *Extended Care Facility Confinement* or part thereof.

Medicare means Title XVIII (Health Insurance Act for the Aged) of the United States Social Security Act, as added by the Social Security Amendments of 1965 as now or subsequently amended.

Medical Coordinator or Underwriters' Medical Coordinator means an organization with a staff who performs the *Certification* processes in conjunction with consultant *Physician(s)* qualified or specializing in the treatment of the condition (including mental *Illness*, alcohol or drug abuse), and arrange or approve certain Medical Transportation.

Nurse Midwife means a person:

1. Certified to practice as a Nurse Midwife;
2. and licensed by a board of nurses as a Registered Nurse (R.N.); and
3. who has completed a program for the preparation of Nurse Midwives, approved by the jurisdiction in which the person is practicing.

Outpatient or Provided on an outpatient basis means that services are provided in the absence of *Hospital Confinement* for more than 24 hours.

Preferred Provider Network means the *Hospitals*, *Physicians*, or other providers who have entered into a contractual agreement with the Underwriters or the Underwriters *Medical Coordinator* or the Plan Administrator to provide *Hospital* and medical services to *Covered Persons* at negotiated fees.

Physician means, with respect to any medical care and service, a person:

1. Certified or licensed, under the laws of the jurisdiction where treatment is rendered, as qualified to perform the particular medical or surgical service for which a claim for coverage under this Certificate of Insurance is made and who is practicing within the scope of such Certification or licenser; and
2. any other health care provider if, and as, mandated by a state's or other jurisdiction's law.

This term does not include an intern or a person in training.

Certificate of Insurance or Group Certificate of Insurance means this document, including the *Employer's* application, and any subsequent amendment or endorsement which the Underwriters issues for attachment to the *Certificate of Insurance*.

Pre-Existing Condition means any *Illness* or *Injury* for which a *Covered Person* received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident, during the 6 months just before his or her effective date of coverage under this *Certificate of Insurance*.

Proof of Good Health means, for the purpose of evaluating late enrollments, satisfactory evidence that an individual is in good health, based on medical information, as the Underwriters may require.

Reconstructive Surgery means surgery which does not itself restore the function of an abnormal body structure and which is incidental to, or the result of, a previous surgery necessary due to *Illness*, *Injury*, or congenital defect.

Reasonable and Customary Charge means the lower of:

1. the provider's usual charge for furnishing the treatment, service or supply; or
2. the charge determined by the Underwriters to be the general rate charged by others who render or furnish such treatments, services or supplies to persons:
 - a. who reside in the same area; and
 - b. whose *Injury* or *Illness* is comparable in nature and severity.

The *Reasonable and Customary* Charge for a treatment, service or supply that is unusual, or not often provided in the area, or that is provided by only a small number of providers in the area, will be determined by the Underwriters. The Underwriters will consider such factors as:

1. complexity;
2. degree of skill needed;
3. type of specialist required;
4. range of services or supplies provided by a facility; and
5. the prevailing charge in other areas.

The term “area” means a city, a county or any greater area that is necessary to obtain a representative cross section of similar institutions or similar treatment.

Reliable Evidence - only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, biological product, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical treatment or procedure.

Qualifying Clinical Trial - the systematic, intensive investigation or evaluation of a drug, biological product, device, medical treatment, therapy or procedure that meets all of the following criteria:

1. investigates a service that falls within a benefit category of the group health benefits plan;
2. is not specifically excluded from coverage;
3. has a therapeutic effect upon enrolled patients with diagnosed disease;
4. is intended to clarify or establish health outcomes of interventions already in common clinical use as defined by the available Reliable Evidence;
5. does not duplicate existing studies;
6. is designed to collect and disseminate Reliable Evidence and answer specific research questions being asked in the trial;
7. is designed and conducted according to appropriate standards of scientific integrity;
8. complies with Federal regulations relating to the protection of human subjects;
9. has a principal purpose to discern whether the service improves health outcomes on enrolled patients with diagnosed disease;
10. is: (1) funded by, or supported by centers or cooperative groups that are funded by: the National Institutes of Health (NIH), Centers for Disease Control and Prevention.(CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA); or (2) conducted under an investigational new drug application (IND) reviewed by the FDA, or an Investigational New Drug Exemption as defined by the FDA;
11. is conducted by a Network Provider. If there is no comparable FDA Approved Clinical Trial being conducted by a Network Provider, the group health benefits plan will consider covering an FDA Approved Clinical Trial being conducted by a Non-Network Provider.
12. In the absence of meeting the criteria listed in (a) - (k) above, the Clinical Trial must be approved by the group health benefits plan as a Qualifying Clinical Trial.

Routine Costs Associated with Qualifying Clinical Trials - Routine costs include:

1. Covered Services under the group health benefits plan that would typically be provided absent a Qualifying Clinical Trial;
2. services and Supplies required solely for the provision of the experimental/ investigational drug, biological product, device, medical treatment or procedure;

3. the clinically appropriate monitoring of the effects of the drug, biological product, device, medical treatment or procedure required for the prevention of complications; and
4. the services and Supplies required for the diagnosis or treatment of complications.

Routine costs do not include the experimental/ investigational drug, biological product, device, medical treatment or procedure itself, the services and Supplies provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and services and Supplies customarily provided by the research sponsors free of charge for any enrollee in the Qualifying Clinical Trial.

Scheduled Hospitalization or Scheduled Confinement means a *Hospital Confinement* that has been planned in advance by a *Covered Person's Physician* for a fixed future time.

Skilled Nursing Care means services provided by, and which require the special skills of, a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

E. ELIGIBILITY FOR INSURANCE

E.1. Eligible Employer or School

The term *Employer* or *School* as used in this *Certificate of Insurance* means an institution named the *Employer* to which this *Certificate of Insurance* is issued, and which:

1. is, and must remain, an institution which is recognized by the appropriate educational authorities as entitled to fulfill its particular educational function;
2. is located outside North America;
3. does not offer other group benefits which in the opinion of the Underwriters essentially conflict with this *Certificate of Insurance*.

The term *School* as used in this *Certificate of Insurance* also includes any group, association, or other organization representing *Expatriate* educators, educational researchers or teachers, on the conditions that:

1. the group be made up entirely of *Expatriates and Key Local Nationals*; and
2. the group's organizers will be responsible for all group coordination, including enrollment, premium payment, and the other functions typically performed by the *Employer*.

If a *School* loses its eligibility for this *Certificate of Insurance* due to failure to meet the required number of participants, or percentage of *Expatriate* population employed, this *Certificate of Insurance* may continue until the next following *Expiration Date*, at which date the *School* may attempt to reestablish its eligibility. If it is unable to do so at that time, the *Certificate of Insurance* will be terminated.

E.2. Eligible Employees

The following *Employees* of *Employers* are eligible for coverage under this *Certificate of Insurance*:

E.2.1. Eligible Employees:

1. Active, full-time *Expatriate Employees* who work for a school, college, university, or other educational institution (including research institutions) located outside the United States, or any of its territories, or Canada; and

2. Active, full-time Employees who are Local Nationals whose position with and responsibility to the Employer are such (Key) as to suggest eligibility for coverage under this Certificate of Insurance if it does not contradict or violate local insurance laws.
3. Eligible Employees include, but are not limited to, teachers, instructors, administrators, business office, and physical facility Employees. The school or institution must be international in character or established primarily to educate students who are not citizens of the country in which the school or institution is located.

A School may not include for coverage under the *Certificate of Insurance*, **Key Local Nationals** in a proportion exceeding 20% of the total insured population of that school.

E.3. Enrollment

It is the responsibility of the *Employer* to provide the Underwriters with correct and up-to-date information pertaining to persons eligible for coverage under the *Certificate of Insurance*, including the addition of newly eligible persons and deletion of departing persons or any other changes that may affect this contract. Failure to do so may jeopardize a *Covered Person's* ability to access the benefits provided.

To enroll for coverage under this *Certificate of Insurance*, an *Employee* must:

1. meet the eligibility requirements described above; and
2. submit a completed enrollment form within 31 days of the date he or she is first eligible for coverage.

At the original Effective Date persons then eligible will be permitted a longer period (to be agreed by the Underwriters) for the completion and submission of enrollment forms.

If the person chooses to decline coverage and then wishes to enroll later, will be considered a Late Enrollee and will not be eligible until the next special enrollment period without providing *Proof of Good Health*. A person may decline enrollment with no penalty provided that on the date at which becomes eligible is currently covered under another group or individual benefit plan. To avoid future restrictions on eligibility, persons who decline enrollment for this reason must provide proof of other group or individual coverage at the time enrollment is declined.

With the exception in the prior paragraph, if the *Employee* submits the enrollment form more than after 31 days after becoming eligible, he or she will be considered a Late Enrollee and will not be eligible to enroll until the next special enrollment period without providing *Proof of Insurability*.

E.3.1. Special Enrollment

For an employee or dependent not enrolled at date of original eligibility.

An otherwise eligible *Employee* and/or their *Dependents* who declined enrollment when first becoming eligible for coverage may enroll within 31 days of loss of coverage under another plan because:

1. continuation coverage has been exhausted; or
2. coverage has terminated due to loss of eligibility.

For the purpose of this provision, "loss of eligibility" means that the individual is no longer eligible due to or as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment. "Loss of eligibility" does not include loss due to failure of the individual or the participant to pay premiums on a timely basis, or for making fraudulent claim or intentional misrepresentation of material facts in connection with the plan.

Change of Dependent Status

An otherwise eligible *Employee* who has elected not to enroll during a previous enrollment period may enroll if acquires a dependent through marriage, birth, adoption or placement for adoption. Enrollment will be accepted no later than 31 days following the date at which a person becomes a dependent of the *Employee*.

E.3.2. Annual Enrollment Period

Once a year, commencing on the new *Effective Date* of the *Certificate of Insurance*, for a period not to exceed 31 days, any eligible *Employee* or *Dependent* who has not enrolled during a previous enrollment period may do so without providing *Proof of Good Health*.

E.4. Effective Date of Coverage

Coverage under this *Certificate of Insurance* for an eligible *Employee* becomes effective, provided the *Employee* submits his or her enrollment form within 31 days of becoming eligible, on the later of:

1. the effective date of this Certificate of Insurance; or
2. the date chosen by the Employer and declared to the Underwriters:
 - a. the date of departure to an Employee's overseas assignment; or
 - b. the date of the Employee's employment contract; or
 - c. the date one, two or three months from the date of departure to an Employee's overseas assignment.

If the date coverage would otherwise become effective falls on a non-work day, coverage will become effective provided the *Employee* was actively at work on the last preceding workday.

E.5. Multiple Coverage

A person is not eligible for coverage under this Certificate of Insurance if covered:

1. as an employee under another Certificate of Insurance, or
2. as both an *Employee* and a *Dependent* under this *Certificate of Insurance*.

E.6. Portability of Coverage

An Employee and his or her Eligible Dependents who are insured under this Certificate of Insurance will be given credit toward satisfaction of any Deductible amount or Out-of-Pocket Limit if the Employee terminates employment with one Employer who holds a Certificate of Insurance issued by the Underwriters and becomes immediately employed by another Employer who holds a Certificate of Insurance issued by the Underwriters with no significant break in coverage.

A significant break in coverage will occur if an Employee's coverage under this Certificate of Insurance terminates and has not enrolled for coverage with a new Employer within 63 days of termination.

E.7. Certificate of Creditable Coverage

An Employee and his or her Eligible Dependents who are insured under this Certificate of Insurance will be provided a Certificate of Creditable Coverage upon termination of coverage as an active Employee or exhaustion of continuation coverage, upon request to the Underwriters. This certificate will be made available upon direct request from the insured person or the new plan's program administrator.

E.8. Eligible Dependents

Dependent or Eligible Dependent means:

1. an Employee's lawful Spouse who is under age 65 at inception of coverage or under age 75 at a renewal of coverage; and
2. each unmarried Child under 19 years of age. "Child" includes an Employee's or his or her lawful Spouse's:
 - a. natural child;
 - b. adoptive child; and
 - c. child under legal guardianship; and
3. each unmarried child over age 19 and under age 24, if such child is a full-time student in an accredited educational institution, such as college, junior college or trade school, and is not employed on a full-time basis.

Each such Child must be legally *dependent* upon the *Employee*, depending principally on the *Employee* for support and maintenance, and permanently living with the *Employee* in a regular parent-child relationship. Proof of full-time status from the educational institution must be provided to the Underwriters upon request.

A person who is eligible as an *Employee* may not be insured as a *Dependent*. No person shall be eligible as a *Dependent* of more than one *Employee*.

E.9. Effective Date of *Dependent* Coverage

Coverage under this *Certificate of Insurance* for Eligible *Dependents*, except for Newborns, will become effective, provided premium is paid on their behalf, on the later of:

1. the date the Employee's coverage becomes effective, provided the Employee has submitted an enrollment form within 31 days, as described above; or
2. the date the Employee acquires newly eligible Dependents, provided has submitted an enrollment form within 31 days, as described below; or
3. the date determined by the "Late Enrollee" provision.

E.10. Exception: Non-Confinement Rule

If, due to an *Injury* or an *Illness*, an *Employee* or *Dependent* is *Confined* in a *Hospital*, an *Extended Care Facility*, or in any other facility which would be covered under this *Certificate of Insurance*, on the date coverage would otherwise become effective, his or her coverage will not start until the day after his or her final discharge from the facility. This requirement also applies to the effective date of any change in benefits.

This Non-Confinement Rule does not apply to a newborn child or to *Dependents* who were insured under an *Employer's* prior group plan on the day before the effective date of coverage under this *Certificate of Insurance*. It will, however, apply to any later change in benefits for such *Dependents*.

Newborn Children: A child born to an *Employee* or to a *Dependent Spouse* insured under this *Certificate of Insurance* and while this *Certificate of Insurance* is in force will be insured from the moment of birth. A newborn child shall be covered for *Injury* and *Illness*, including care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth.

Coverage shall continue provided an enrollment form has been completed and submitted within 31 days of the child's birth and premium has been paid on his or her behalf. If the child is not properly enrolled within the 31 day period, will be considered a Late Enrollee, and *Proof of Good Health* will be required, at

the *Employee's* expense. Coverage for the child may or may not be approved, as described below in the provision titled "Late Enrollees."

Newly Adopted Children: Coverage for a child adopted while an *Employee's* coverage under this *Certificate of Insurance* is in effect will become effective on the date of placement for the purpose of adoption and continues unless the placement is disrupted and the child is removed from placement.

Coverage for a newly adopted child will be the same, and subject to the same terms and conditions, as described above for a newborn child.

E.11. Enrollment of Newly Eligible Dependents

To enroll a new *Spouse* or newly eligible children under this *Certificate of Insurance*, an *Employee* must submit a completed enrollment form to the Underwriters as follows:

Marriage: The *Employee* must submit an enrollment form within 31 days after the date of the marriage and provide to the Underwriters such documentation of the marriage as the Underwriters may reasonably require.

Newborn: The *Employee* must submit an enrollment form within 31 days after the date of birth.

Adopted Child: The *Employee* must submit an enrollment form within 31 days after:

the date of filing a petition to adopt, if the child has been living in the *Employee's* home as a foster child for whom the *Employee* has received foster care payments; or

in all other cases, the date of his or her placement in the *Employee's* home, by a licensed placement agency, for the purpose of adoption. The *Employee* must provide to the Underwriters appropriate documentation of the relationship, as the Underwriters may reasonably require.

Children under Legal Guardianship: The *Employee* must submit an enrollment form within 31 days after the *Employee* has been appointed legal guardian by a court.

The *Employee* must provide such appropriate documentation of the relationship to the Underwriters as the Underwriters may reasonably require.

E.12. Termination of Employee Coverage due to the School's Loss of Eligibility

If a *School* loses its eligibility for this *Certificate of Insurance* due to failure to meet the required number of participants, or percentage of expatriate population employed, the *Certificate of Insurance* will be terminated and *Employees* currently insured will be given the option to elect *Continuance* under Section I.

If a *School* loses its eligibility as specified in section E.1, the *Insured Person's* coverage will automatically terminate according to the provisions of the *Certificate of Insurance*, and *Employees* currently insured will not be given the option to elect *Continuance* coverage.

E.13. Other Termination of Employee Coverage

Except as provided under Extension of Benefits, an *Employee's* coverage under this *Certificate of Insurance* will terminate on the first of the following dates:

1. the date this *Certificate of Insurance* terminates for reasons other than stipulated in section E.12;
2. the date the *Employee's* Employer ceases to be the Employer;

3. the date the Employer discontinues or suspends active business operations; or changes the nature of business; or no longer exists because of dissolution, merger or otherwise;
4. the date the Underwriters ceases to renew coverage for any class or classes of business under which an Employee is covered. A Covered Person's coverage will be terminated in this manner only if the Underwriters terminate all Covered Persons in the same class or classes. The Underwriters will notify the Employer or the Covered Persons 90 days prior to termination.
5. the date the Maximum Benefit amount under this Certificate of Insurance has been paid to or on behalf of the Employee;
6. the last day of the calendar month during which the Employee ceases to be an active, full-time Employee of a Employer or otherwise ceases to be an Eligible Employee, or, if earlier, the date he or she becomes entitled to similar benefits under another health plan;
7. the date premium payments to the Underwriters, on his or her behalf, cease;
8. the date the Employee fails to make any required contribution, when due; or
9. the date the Employee dies.

E.14. Termination of *Dependent* Coverage

Except as provided below and under Extension of Benefits, a *Dependent's* coverage under this *Certificate of Insurance* will terminate on the first of the following:

1. the date this Certificate of Insurance terminates for reasons other than stipulated in the section E.12;
2. the date the Maximum Benefit amount under this Certificate of Insurance has been paid to or on behalf of the Dependent;
3. the date the Employee's coverage under this Certificate of Insurance terminates, or on the last day of the month in which the Employee's death occurred;
4. the last day of the month after the date a Spouse or child ceases to satisfy the Certificate of Insurance's definition of an Eligible Dependent;
5. the date the Spouse or child becomes insured as an Employee under this Certificate of Insurance; or
6. the last day of the calendar month during which a Dependent of an Employee has taken return trips to the U.S. totaling a minimum of 90 consecutive days in a policy year unless attending school while an Eligible Dependent.

Exceptions:

1. A *Dependent* Child's coverage under this *Certificate of Insurance* may continue provided premiums continue to be remitted to the Underwriters on his or her behalf, if such *Dependent* is physically handicapped or mentally retarded.
2. Coverage under this *Certificate of Insurance* for an unmarried physically or mentally handicapped child may continue beyond the limiting age if:
 - a. on the date he or she attains the limiting age, the child is incapable of self-sustaining employment because of mental or physical handicap;
 - b. he or she became so incapacitated before attaining the limiting age;
 - c. he or she is chiefly Dependent on the Employee for support and maintenance; and
 - d. medical expense coverage under the Continuation of Coverage section of the Certificate of Insurance has not been issued to such child.

If a claim is denied under this *Certificate of Insurance* because the child has reached the limiting age, it is the *Employee's* responsibility to establish and to furnish proof to the Underwriters that the child is and continues to be physically or mentally handicapped, as noted above.

E.15. Termination of Continued Coverage for Physically or Mentally Handicapped Dependents

Coverage may continue until the first of the following dates:

1. the date the incapacity ceases;
2. the date the Employee fails to submit, for the Dependent child, any required proof of continuing incapacity;
3. the date the Employee fails to allow the Dependent child to submit to any required examination;
4. the date such Dependent's coverage under this Certificate of Insurance terminates for any reason other than attainment of the limiting age;
5. the date the Dependent becomes eligible for coverage under another group plan;
6. the day a required premium is due and unpaid;
7. the date this Certificate of Insurance terminates; or
8. the date the Maximum Benefit amount under this Certificate of Insurance has been paid to or on behalf of the *Dependent*.

F. HEALTH INSURANCE BENEFITS - DESCRIPTIONS

Health Insurance Benefits will be payable upon receipt of due proof that an *Employee* or *Dependent*, while insured under this *Certificate of Insurance*, incurs Covered Medical Expenses for treatment of an *Injury* or *Illness* covered under this *Certificate of Insurance*.

F. 1. Covered Medical Expenses

Covered Medical Expenses or *Covered Expenses* are the *Reasonable and Customary Charges* for the following *Medically Necessary* treatment, services and supplies.

1. Physician's services
Surgery, *Hospital* care, and home and office care.
2. Hospital Confinements.
 - a. Room and board charges, up to semiprivate rates. Private room charges that exceed semiprivate rates are not covered.
 - b. Charges for an intensive care unit and other special units;
 - c. Charges for other *Hospital* services and supplies (except personal or comfort items), including, but not limited to, general nursing care; drugs and medications; biologicals; anesthesia and oxygen; the administration of whole blood or blood plasma, laboratory tests and X-rays; and use of operating and recovery rooms.
3. Hospital emergency room.
4. Emergency care received for an Injury or a Medical Emergency.
5. Outpatient services.

Scheduled outpatient surgery or diagnostic testing in a *Hospital* or other outpatient treatment in a *Hospital* or other facility covered under this *Certificate of Insurance*.

6. Ambulatory Surgical Center.

Ambulatory Surgical Center for surgical treatment, services and supplies if such treatment, services and supplies would have been covered under this Certificate of Insurance if the Covered Person had been Confined in a Hospital or Extended Care Facility.

7. Outpatient Skilled Nursing Care.

Services provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.). Benefits are payable if the services rendered require the skills of a duly licensed R.N., L.P.N., or L.V.N. Only that portion of such Skilled Nursing Care that requires the skills of an R.N., L.P.N., or L.V.N. is covered under this Certificate of Insurance. Benefits are payable as shown in the Schedule of Benefits.

8. Private duty nursing.

a. Benefits are payable for services provided by a nurse practicing within the scope of such nurse's local professional license.

b. In addition to the General Exclusions within this provision, no private duty nursing service benefits are payable for charges incurred in the U.S.

9. Local professional ground ambulance service

Ambulance service to a local *Hospital* or *Extended Care Facility*.

10. Emergency Local Transportation.

Following an *Injury* that requires emergency treatment and that prevents the *Covered Person* from using normal modes of transportation to the nearest *Hospital* or clinic, the Underwriters will pay the cost of emergency transportation.

Emergency transportation may also be required following a sudden *Illness* that is debilitating in nature or following sudden degradation of the medical condition while under treatment and which requires immediate and emergency medical attention. The *Covered Person's* condition must be such at time of emergency admission that prevented him or her from using normal modes of transportation.

11. Remote Medical Transportation.

If, after the *Covered Person* receives the first treatment required to stabilize the medical situation in a *Hospital* or a clinic, the person's condition is still considered to be life-threatening by the treating *Physician*, and confirmed as to be such by the Underwriters *Medical Coordinator*, the Underwriters will pay the cost of Remote Medical Transportation to the nearest suitable medical facility, even if such medical facility is in a country other than the country where the *Injury* or *Illness* occurred, if the necessary treatment is not available in the *Hospital* or clinic where the *Covered Person* is, and therefore, medical transportation is considered *medically necessary*.

The *Covered Expenses* of Remote Medical Transportation will include:

- a. direct cost and other *Reasonable and customary* expenses arising out of travel
- b. medical care in the new Hospital
- c. accommodation charges with respect to the person's transportation to the designated location
- d. costs associated with the necessary appropriate return transportation, when the person's situation is stabilized or when the person has recovered.

"Appropriate return transportation" means the transportation:

- a. to go back to the first Hospital, if needed
- b. to go to another Hospital near the Covered Person's residence, in order to go through a rehabilitation phase or convalescence phase and where the person can receive the necessary follow-up treatment, or
- c. to return to the Covered Person's residence

12. Emergency Reunion.

- a. When the *Covered Person's Physician* indicates that it would be beneficial to have a family member at the person's side during a medical transportation *or during Hospitalization expected to last at least 10 days*, The Underwriters will pay the travel and lodging expenses incurred by that relative, provided that the necessity is confirmed by the Underwriters *Medical Coordinator* and that all travel arrangements are coordinated by the Underwriters *Medical Coordinator*.
- b. The eligible expenses of Emergency Reunion include:
 - i. If the Covered Person has no relative in the country where Hospitalized, the cost of an economy air ticket for one relative from the *Covered Person's Country of Residence or Home Country*, whichever is less expensive, to the airport serving the area where the *Covered Person is Hospitalized*;
 - ii. a return ticket to that country; and
 - iii. reasonable travel and lodging expenses by that person on that trip for a maximum of 10 days, including the travel time.

13. Transportation to Residence in Country of Assignment

Following an emergency medical situation which occurs while the *Covered Person* is away from his or her residence, the Underwriters will pay (in addition to paying the necessary *Hospitalization* costs incurred, once the person's medical situation has been stabilized) the cost of transportation to the *Covered Person's Country of Residence*, to his or her residence or to a *Hospital* near it, so that the person can obtain any immediate medical attention that is necessary if the person cannot use a normal mode of transportation for his or her return.

The transportation to the *Covered Person's residence* in the *Covered Person's Country of Assignment* Benefit is subject to a maximum of the limit shown in the *Schedule of Benefits*.

14. Repatriation of Bodily Remains

In the event of the *Covered Person's* death, the Underwriters will pay the cost of repatriation of the *Covered Person's* body or ashes to the International airport nearest the *Covered Person's* address in the *Covered Person's Home Country*. Costs of the legal procedures and costs of the necessary preparations for the transportation of the mortal remains will be paid, as well as the costs of the legal procedures and charges for or in connection with the transportation of the mortal remains in using the minimal usual container internationally approved by IATA. The costs of a coffin or casket are not included.

The repatriation of bodily remains benefit is subject to a maximum of the limit shown in the *Schedule of Benefits*.

15. General Considerations for all Medical Transportation.

The Medical Transportation benefit, Transportation to the *Employee's* Residence in the *Covered Person's* Country of Assignment, Repatriation of Bodily Remains Benefit and Emergency Reunion Benefit must be:

- a. directly related to an *Injury* or a *Illness* covered by this *Certificate of Insurance*, and
- b. Pre-Certified, confirmed and coordinated by the Underwriters Medical Coordinator.

In the absence of medical contraindication, the Underwriters may require that the person be transported to the *Covered Person's* residence, to a *Hospital* in the *Covered Person's* Country of Assignment or that the person be transferred to any other medical facilities.

Together, the medical transportation benefit is limited to the amount shown in the Schedule of Benefits.

The *Covered Person* must bear any other costs of transportation, medical or otherwise, including accommodations and other expenses.

16. Physical Examinations.

Reasonable and Customary charges incurred for the physical examinations, including mammography, prostate screening, and necessary inoculations, provided to the Insured Person while covered under this Certificate of Insurance. To be payable, the services must be performed under the direction of a *Physician*.

17. Rehabilitative therapy.

Charges incurred for the following rehabilitative therapy: physical, occupational, speech, vision and cardiac/pulmonary therapy, if prescribed by the attending Physician to restore function loss due to an *Illness* or *Injury* which occurs while covered under this Certificate of Insurance.

18. Drugs and Medications

Drugs and medications that, by law, require a Physician's prescription, including anti malarial drugs and which must be dispensed by a licensed pharmacist, except as excluded under General Exclusions.

The Underwriters will attempt to provide the services of an independent Prescription Drug Service for the benefit of those *Covered Persons* who require longer-term medication. The costs and charges associated with delivery of drugs and medications by this service will be considered covered expenses.

19. Allergy Testing and Injections.

20. Casts, splints, trusses, orthopedic braces and crutches;

21. The administration of blood and blood plasma. However, no benefits are payable for the cost of blood or blood products which are replaced;

22. X-ray and laboratory diagnostic examinations;

23. X-ray, radium and radioactive isotope therapy;

24. Anesthesia, oxygen, and other gases and their administration;

25. Home Health Care.

- a. Benefits are payable, as shown in the Schedule of Benefits, for the following *Home Health Care Charges* if made:
- b. by a Home Health Care Agency;

- c. for services furnished to a Covered Person in his or her home; and
- d. in accordance with a Home Health Care Plan, for:
 - i. Part-time or Intermittent nursing care by a registered graduate nurse (R.N.), licensed vocational nurse (L. P.N.);
 - ii. Part-time or Intermittent home health aide services which consist primarily of medical or therapeutic caring for the patient, if under the supervision of a registered nurse or duly licensed physical, occupational, or speech therapist;
 - iii. Physical therapy, occupational therapy, and speech therapy, if provided by the Home Health Care Agency; and
 - iv. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services, but only to the extent such items or services would have been covered under this Certificate of Insurance if the Covered Person had been Confined in a Hospital or Extended Care Facility.

In addition to the General Exclusions applicable to this provision, no Home Health Care benefits are payable for:

- i. services or supplies which are not specified in the Home Health Care Plan;
- ii. services rendered in a Hospital or in an institution primarily engaged in providing skilled nursing or rehabilitation services;
- iii. any services or supplies provided for a person in the household other than the patient;
- iv. Custodial Care; or
- v. transportation services.

26. Durable Medical Equipment.

Benefits are payable for the rental of *Durable Medical Equipment* including, but not limited to, non-motorized wheelchairs and *Hospital-type* beds.

The option of renting or purchasing will be determined by cost. The Underwriters will require that the most economical option be selected.

In addition to the General Exclusions applicable to provision, no *Durable Medical Equipment* benefits are payable for:

more than one item of equipment for the same or similar purpose;
 an amount which exceeds the cost of a similar supply which would have been sufficient to safely and adequately treat the Covered Person's physical conditions; or
 the cost to repair or replace damaged equipment, **whichever the lesser cost.**

27. Prosthetic devices.

Charges incurred for the purchase of prosthetic devices, such as artificial limbs, larynx and eyes (except prosthetic devices for TMJ). Benefits are payable for the initial purchase and fitting of such devices and for replacements which are functionally necessary, but only if required for the replacement of natural parts of the body lost as the result of any *Injury* or *Illness* which occurs while a *Covered Person* is covered under this *Certificate of Insurance*.

28. Reconstructive Surgery.

Benefits are payable only when *Reconstructive Surgery*, which does not itself restore the function of an abnormal body structure and which is incidental to, or a previous surgery necessary due to *illness* Injury, or congenital defect, is:

- a. medically necessary; and
- b. incidental to treatment of a disease; or
- c. due to a mastectomy performed while the Covered Person is covered under this Certificate of Insurance; or
- d. needed to correct a congenital disease or anomaly to restore vital or necessary bodily functions for a Covered Person covered under this Certificate of Insurance from birth.

29. Mental Illness.

Benefits include charges for the treatment of mental disease or disorder, emotional disorder or functional nervous disorder, as classified by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders. Benefits are payable as shown in the Schedule of Benefits.

30. Maternity.

Benefits include charges for prenatal care, delivery, postnatal care, and Complications of Pregnancy. Benefits for prenatal care, delivery, and postnatal care are payable only for maternity expenses incurred by an Employee or Spouse of an Employee covered under this Certificate of Insurance. Benefits are payable as shown in the Schedule of Benefits.

31. Newborn child.

Benefits are payable for the care of a newborn child for:

- e. six physical examinations and testing required during the first year of life to establish good health;
- f. medically necessary immunizations;
- g. treatment of *Injury* or *Illness*;
- h. treatment of medically diagnosed prematurely, congenital defects, or birth abnormalities; and
- i. routine *Hospital* and *Physician* care during the post-partum *Hospital Confinement* period.

32. Hospice care

Benefits are payable, as shown in the Schedule of Benefits, for expenses incurred for the following *Hospice* Care:

- a. room and board and other necessary services and supplies furnished while confined in a Hospice;
- b. part-time nursing care by or under the supervision of a registered nurse (R.N.);
- c. home health aide services under the supervision of a registered nurse, nutrition services and special meals;
- d. counseling services by a licensed social worker or licensed pastoral counselor; and
- e. bereavement counseling by a licensed social worker or licensed pastoral counselor for the patient's family members who are also covered under this Certificate of Insurance, but not beyond 6 months from the patient's date of death;
- f. but only if the patient's Physician certifies that is not expected to live for more than six months;

In addition to the General Exclusions applicable to this provision, no *Hospice* Care benefits are payable for charges incurred outside the U.S.

33. Birth Center

Benefits are payable for charges made by a *Birth Center* for care and treatment of a covered pregnancy. *Covered Expenses* include charges for:

- a. room and board and other Medically necessary services and supplies; and
- b. anesthesia and its administration.

34. Nurse Midwife.

Covered Expenses include Charges made by a Nurse Midwife for services provided in connection with an uncomplicated delivery.

35. Spinal-skeletal disorders.

Covered Expenses include Charges for the detection and the non-surgical treatment of subluxation or misalignment of the vertebral column in the human body, for purposes of alleviating pressure on spinal nerves and its associated effects related to such misalignment or distortion, by physical or mechanical means. Benefits are payable as shown in the Schedule of Benefits;

36. Transplants Treatment

Subject to the Terms of this insurance, including without limitation the Deductible, Benefit Percentage, and limits and sub-limits set forth in the Schedule of Benefits, and the Exclusions contain herein, the Underwriters will reimburse the *Covered Person* for the following costs, charges and expenses incurred by the *Covered Person* while this Certificate is in effect, so long as such costs, charges and expenses are Reasonable and Customary:

- a. *Covered Expenses* incurred by a live donor will be treated as if they were the expenses of the *Covered Person* receiving a Covered Transplant if the *Covered Person* received an organ or tissue of the live donor, and limited to a lifetime maximum of \$10,000; and
- b. Organ procurement and harvesting costs, excluding acquisition or purchase of the actual organ or tissue, up to a lifetime maximum of \$10,000; and
- c. Charges incurred for pre-transplant evaluation, the Covered Transplant procedure, re-transplantation (if incurred during the initial Covered Transplant hospitalization), and post-transplant care; and
- d. Reasonable travel and lodging expenses of the Covered Person if travel of more than 50 miles is necessary to receive the Covered Transplant treatment and services from Preferred Provider, up to a lifetime maximum of \$5,000.

37. Routine costs associated with qualifying clinical trials

Benefits are provided for Routine Costs Associated With Qualifying Clinical Trials (see the DEFINITIONS section). To ensure coverage, the group health benefits plan must be notified in advance of the Covered Person's participation in a Qualifying Clinical.

F.2. How Benefits are Payable

Benefits for Covered Medical Expenses will be payable at the percentage rate shown in the Schedule of Benefits, after any *Deductible* amount which may apply. All benefits are subject to the Definitions, benefit limitations, and Exclusions in this *Certificate of Insurance*. All benefit payments will be made in U.S. dollars, using the official exchange rate in effect the day that a Covered Medical Expense is incurred. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro-rata share of the charge.

F.3. Deductibles

A *Deductible* is the dollar amount which a *Covered Person* is responsible to pay before Health Insurance Benefits are payable under this *Certificate of Insurance*. This amount will not be reimbursed under this *Certificate of Insurance*. Any and all *Deductible* amounts are shown in the Schedule of Benefits and in any Endorsement or Amendment that is or becomes part of this *Certificate of Insurance*.

F.4. Family Limit on Deductibles

For each family insured under the *Certificate of Insurance* there is a limit to the dollar amount that will apply toward the family members' combined *Deductibles*. The Family *Deductible* amount is shown in the Schedule of Benefits. When the Family *Deductible* has been satisfied in a policy year, no additional *Deductible* will be required of any family members for the remainder of that calendar year.

F.5. Out-of-Pocket Limit

When the percentage a *Covered Person* or a family pays for Covered Medical Expenses, **after the *Deductible***, totals an amount equal to the *Out-of-Pocket Limit* shown in the Schedule of Benefits, this *Certificate of Insurance* will pay 100% of *Reasonable and Customary Charges* for any further Covered Medical Expenses incurred by the *Covered Person(s)* during the remainder of that policy year. Benefits will continue to be subject to this *Certificate of Insurance's* conditions, limitations, benefit maximums and exclusions.

The *Out-of-Pocket Limit* does **not** include amounts which:

1. are used to satisfy the Deductible amount;
2. are in excess of Reasonable and Customary Charges;
3. are incurred for treatment, services, or supplies which are not covered under this Certificate of Insurance;
4. are in excess of Benefit limitations;
5. are incurred for the treatment of mental or nervous disorders;
6. a Covered Person is required to pay as a result of a reduction in benefits due to not following the Certificate of Insurance's Pre-Certification and Benefits Management Program; or
7. are noted as not applying to this limit in any Endorsement or Amendment to this Certificate of Insurance

F.6. Maximum Benefit

Maximum Benefit, as shown in the Schedule of Benefits, means the total amount of Health Insurance Benefits payable at any time under this *Certificate of Insurance*, even if a *Covered Person's* coverage is interrupted, or terminated and subsequently reinstated. The *Maximum Benefit* payable for Health Insurance Benefits under this *Certificate of Insurance* includes any and all benefits paid under this *Certificate of Insurance*.

Any unused portion of the *Maximum Benefit* is only payable for expenses incurred while the *Covered Person* is eligible for coverage while this *Certificate of Insurance* is in force; or is eligible under the Extension of Benefits Provision of this *Certificate of Insurance*; or eligible under any applicable continuation provision.

G. GENERAL EXCLUSIONS

G.1 Pre-Existing Conditions

Any expenses incurred during the first 12 consecutive months of a *Covered Person's* coverage under this *Certificate of Insurance* that are due to Pre-existing conditions are not covered unless credit is given for

prior coverage under this section. The exclusion period of *Pre-existing Conditions* is extended to 18 months for Late Enrollees.

For the purpose of this Certificate of Insurance, *Pre-Existing Condition* means any *Illness* or *Injury* for which a *Covered Person* received any diagnosis, medical advice or treatment, or had taken any prescribed drug, or where distinct symptoms were evident, during the 6 months immediately preceding his or her effective date of coverage under this *Certificate of Insurance*.

In determining whether this *Pre-Existing Condition* exclusion applies to an occurrence of expense, credit will be given for the time the *Covered Person* was covered under a previous group or individual health benefit plan, provided the previous coverage was continuous with no significant break in coverage before the effective date of the person's coverage under this *Certificate of Insurance*, exclusive of any applicable waiting period. Evidence of coverage must be provided to the Underwriters on request.

Significant break in coverage means a period of 63 consecutive days during all of which the individual did not have any creditable coverage.

Any period accumulated under a waiting period or an affiliation period under a previous or current coverage will not count toward the calculation of a significant break in coverage.

G.2 Additional General Exclusions for Medical Benefits

In addition to any specific limitations or exclusions specified elsewhere in this *Certificate of Insurance*, no benefits are payable under this *Certificate of Insurance* for:

1. vision exams or hearing exams (except when necessary because of accidental *Injury* to a natural eye or ear, sustained while under this *Certificate of Insurance* if such eye refraction or examination is also performed while insured); eyeglasses or contact lenses or their fitting (except contact lenses required due to cataract surgery); hearing aids, or their fitting, or cochlear implants; dental exams; or orthopedic shoes or other supportive devices for the feet, such as, but not limited to, arch supports and orthotic devices (unless specifically provided by *Certificate of Insurance* Endorsement); or any other preventive services and supplies;
2. expenses due to an *Injury* or *Illness* that is covered under a worker's compensation law, occupational disease law, or similar laws, whether or not such benefits have been applied for or paid;
3. mental conditions, except as specifically provided in *Covered Medical Expenses* and as shown in the *Schedule of Benefits* or by *Certificate of Insurance* endorsement;
4. alcohol abuse or alcoholism, or drug abuse or drug addiction;
5. expenses in excess of any *Maximum Benefit* limit which has been reached, for the rest of the period of time to which such limit applies;
6. expenses incurred on or after the date insurance under this Certificate of Insurance stops, except to the extent allowed in the Extension of Benefits provision in this Certificate of Insurance;
7. communications, or travel, even if prescribed by a Physician, or travel time; or travel and transportation expenses to receive consultation or treatment, unless specifically provided by the Certificate of Insurance;
8. treatment of an *Illness* or *Injury* resulting from war or any act of war, declared or undeclared;
9. voluntary participation in an assault, felony, insurrection, or riot;

10. treatment, including diagnosis, of:
 - a. weak, strained unstable or flat feet or fallen arches; or
 - b. any tarsalgia, metatarsalgia or bunion, except for operations which involve the exposure of bones, tendons or ligaments; or
 - c. superficial lesions of the feet, such as corns, calluses and hyperkeratoses; or
 - d. toe nails, other than removal of nail matrix or root;
11. except as noted in Covered Medical Expenses, the following drugs, medicines or supplies, even if prescribed by a Physician:
 - a. *Experimental or Investigative* drugs, medicines, or supplies,
 - b. The vitamins, dietary supplements, appetite or smoking suppressants, sexual stimulants, hair regenerative or antiphotaging drugs; cosmetics, or health and beauty aids;
 - c. over-the-counter (OTC) drugs or supplies, which do not require a *Physician's* authorization by the jurisdiction where the drug or supply is prescribed, and any prescription that is available as an OTC medication, even if prescribed by a *Physician*;
 - d. contraceptive drugs or devices, prescription or otherwise, even if prescribed for other than contraceptive purposes; or
 - e. drugs prescribed for non-medical conditions, or drugs for conditions which are not covered under this *Certificate of Insurance*;
12. treatment (including Hospitalization), services, or supplies which:
 - a. are not *medically necessary*, even if they are:
 - i. prescribed, recommended or approved by a *Physician* or *Dentist*; or
 - ii. ordered by a court of law;
 - b. are *Experimental or Investigative*, or under clinical investigation by health professionals;
 - c. are provided and independently billed by interns, residents or other *Employees of Hospitals*, laboratories or other medical facilities;
 - d. are furnished, paid for, or for which benefits are provided by, under, or in accordance with the law of the jurisdiction where treatment is obtained (this does not include Medicaid.); or
 - e. are furnished by a Veterans Administration facility for a service-connected *Injury or Illness*; or which are provided or reason of the *Covered Person's* past or present service in the armed forces of a government, to the extent permitted by law; or
 - f. are rendered by a person who ordinarily resides in the *Covered Person's* home or is a member of the family (father, mother, brother, sister or child) of the *Employee* or of his or her *Spouse*; or
 - g. are due to intentional self-inflicted *Injury* or attempted self-destruction, while sane or insane;
13. expenses which:
 - a. exceed the *Reasonable and Customary* Charge for a service;
 - b. would not have been made in the absence of insurance; or
 - c. a *Covered Person* is not legally obligated to pay;
14. the following surgical procedures and related services or supplies, including, but not limited to, *Hospital Confinement*, prescription drugs, and diagnostic laboratory tests or X-rays:
 - a. cosmetic or plastic surgery, or other services and supplies, to repair or reshape an essentially normal body structure for the improvement of a *Covered Person's* appearance or self-esteem, whether or not for psychological or emotional

- reasons except: 1) for correction of damage caused by accidental *Injury* sustained while insured if such treatment or surgery is also performed while so insured; or 2) in connection with a congenital defect, malformation or birth abnormality of a newborn child;
- b. radial keratotomy surgery or eye surgery mainly to correct refractive errors;
 - c. for treatment or surgery to change gender or to improve or restore sexual function, including but not limited to penile prosthesis; or
 - d. the reversal of a sterilization procedure, or any other birth control procedures, except abortions if the life of the mother is in danger
 - e. the treatment of a jaw/joint disorder diagnosed as Temporomandibular Joint Dysfunction (TMJ) or Myofacial Pain Dysfunction (MPD), or other similar term (except for excision or reduction of the temporomandibular joint) or ;
- 15. artificial insemination, in vitro or in vivo fertilization, or similar services or procedures for the purpose of impregnation, which do not treat or correct a physical condition causing infertility;
 - 16. weekend Charges incurred for Hospital Confinements that start on Friday, Saturday or Sunday, unless:
 - a. the attending *Physician* certifies that such weekend admission is *Medically Necessary*; or
 - b. such weekend *Hospital Confinement* is in connection with a surgery *Scheduled* for the day that next follows the date of admission (Saturday, Sunday or Monday);
 - 17. treatment of obesity, except treatment of Endogenous Morbid Obesity diagnosed by a *Physician*;
 - a. Endogenous Morbid Obesity means 100 or more pounds over ideal weight, as determined by The Metropolitan Height & Weight Tables for Men and Women which is caused by some metabolic abnormality.
 - 18. *Custodial Care*, domiciliary care and unskilled *Home Health Care*, including, but not limited to, long-term therapy and maintenance care for chronic conditions. Home health aide services are covered only as described in Covered Medical Expenses for *Home Health Care*;
 - 19. dental care or treatment of the teeth or gums, whether or not in connection with a jaw condition, except charges incurred for the repair or replacement of sound natural teeth damaged by an *Injury* which occurred while insured under this *Certificate of Insurance* and within 12 months from the date of the *Injury*;
 - 20. personal or comfort items;
 - 21. any services and items not included in this *Certificate of Insurance* as covered;
 - 22. *charges* by any provider of care or service who or which is not duly licensed or *Certified*; or
 - 23. charges for maternity care for *Dependent* children, except for *Complications of Pregnancy*.

G. 3 RADIOACTIVE CONTAMINATION EXCLUSION CLAUSE - PHYSICAL DAMAGE DIRECT-(U.S.A)

This Policy does not cover any loss or damage arising directly or indirectly from nuclear reaction, nuclear radiation or radioactive contamination however such nuclear reaction, nuclear radiation or radioactive contamination may have been caused *NEVERTHELESS if Fire is an insured peril and a Fire arises directly or indirectly from nuclear reaction, nuclear radiation or radioactive contamination any loss or damage arising directly from the Fire shall (subject to the provisions of this Policy) be covered EXCLUDING however all loss or damage caused by nuclear reaction, nuclear radiation or radioactive contamination arising directly or indirectly from that Fire.

*Note - If Fire is not an insured peril under this Policy the words "NEVERTHELESS" to the end of the clause do not apply and should be disregarded.

H. EXTENSION OF BENEFITS

H.1. Extension of Medical Benefits

If a *Covered Person* is *Confined* in a *Hospital* on the date his or her coverage under this *Certificate of Insurance* would otherwise terminate, his or her coverage under this *Certificate of Insurance* will be extended until the first of the following dates:

1. the date the *Covered Person* is discharged from the *Hospital*
2. the date of eligibility for Medicare coverage
3. 30 days after the date coverage would otherwise cease, or
4. the date the Maximum Benefit amount under this Certificate of Insurance has been paid to or on behalf of the *Covered Person* for whom benefits are being extended under this provision.

This additional coverage is subject to all conditions of the Certificate of Insurance which it does not specifically modify.

J. COORDINATION OF MEDICAL BENEFITS

This provision applies when an *Employee* or *Dependent* insured for Health Insurance and Dental Benefits (if applicable) under this *Certificate of Insurance* has, or is entitled to benefits as a result of, any other Plan, as defined below. It is intended to prevent payment of benefits that exceed 100% of the Allowable Expenses incurred. This provision applies whether or not a claim is filed under the other Plan(s).

J.1. Definitions Related to This Provision

Allowable Expense means any necessary, *reasonable and customary* item of medical or dental expense which is covered, in whole or in part, under at least one of the Plans covering the claimant. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered an Allowable Expense and a benefit paid. When a Plan uses capitation as the method of paying its providers of services, the reasonable value of such services shall be utilized as the basis of determining payment.

If a benefit is payable under another Plan, it will be considered an Allowable Expense and a benefit payment made under such other plan, whether or not a claim was filed under such other Plan. With regard to *Medicare*, to the extent permitted by law, Allowable Expenses include benefits payable under Part A and Part B.

“Allowable Expense” does not include the difference between the cost of a private *Hospital* room and the cost of a semiprivate room, unless the patient’s stay in a private room is *medically necessary*.

Claims Determination Period means the period from January 1 through December 31, or that portion of a policy year during which the claimant was insured under this *Certificate of Insurance*.

Group-type Contract means a contract for coverage, which is not available to the general public and can be obtained and maintained only because of membership in, or connection with a particular organization or group. A Group-type Contract may be an insured or uninsured arrangement and may be an individual contract form.

Plan means any of the following that provide full or partial benefits or services for medical or dental care or treatment, on an insured or uninsured basis:

1. Group, Group-type Contract, or blanket insurance (except school accident policies);
2. and group Blue Cross, Blue Shield, group practice or other pre-payment coverage on a group basis, including health care service contracts and health maintenance organization group agreements;
3. labor-management trustee plans, union welfare plans, Employer organization plans; or Employee benefits plans, or any other arrangement of benefits for individuals of a group;
4. the amount by which Hospital indemnity benefits exceed \$100 per day;
5. Medicare or other government programs, but only to the extent permitted by law, or coverage required or provided by law, but not including Medicaid; and
6. the medical benefits coverage in automobile policies to the extent permitted by law.

“Plan” will be construed as a separate Plan for each:

1. *Certificate of Insurance*; and contract; and other arrangement for benefits or services; and
2. *portion of any Certificate of Insurance; contract; or other arrangement for benefits; which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits, and separately for that portion which does not reserve the right.*

Primary Plan means the medical Plan that determines its benefits without taking other Plans’ benefits into consideration. The Primary Plan is as determined by the Order of Benefit Determination rules, described below.

Secondary Plan means the medical Plan(s) which determine benefits for the claimant after the Primary Plan determines benefits. Benefits under the Secondary Plan may be reduced because of the Primary Plan’s benefits. The Secondary Plan(s) is (are) as determined by the Order of Benefit Determination rules, described below.

J.2. Order of Benefit Determination

When a claim under this *Certificate of Insurance* involves another Plan which also has a Coordination of Benefits provision, the following rules will determine the order in which the benefits are payable under the respective Plans.

If a Plan does not have a Coordination of Benefits provision or order of benefit determination rules, it is the Primary Plan.

The following rules determine which Plan is the Primary Plan and which Plan is the Secondary Plan in all other cases:

Employee

1. The Plan is Primary if it covers the claimant as an active *Employee*.
2. If two Plans cover the claimant as an *Employee*, the Plan that has covered him or her for the longer period of time is the Primary Plan.
3. If an *Employee* is covered as an active *Employee* under the Plan and as a retired or laid off *Employee* under another Plan, the Plan that covers him or her as an active *Employee* is the Primary Plan. The Plan covers him or her as a retired or laid off *Employee* is the Secondary Plan.
 - a. If the other Plan does not have a provision regarding laid off or retired *Employees*, which results in each Plan determining its benefits after the other, then this rule shall not apply.

Dependent Child whose Parents are not Divorced or Separated

If a child is insured, under two or more Plans, as a *Dependent* of parents who are not divorced or separated, benefits for the child are determined in the following order:

1. If the Plan of the parent whose birthday (month and day only) falls earlier in the policy year is the Primary Plan. The Plan of the parent whose birthday falls later in the policy year is the Secondary plan.
2. If both parents have the same birthday (month and day only), the Plan that has covered the parent for the longer period of time is the Primary Plan. The Plan that has covered the parent for the shorter of time is the Secondary Plan.

Dependent Child whose Parents are Divorced or Separated

If a child is insured, under two or more Plans, as a *Dependent* of parents who are divorced or separated, benefits for the child are determined in the following order:

1. The plan of the parent bound by a court decree to be financially responsible for the medical, dental or other health care expenses of the child is the Primary Plan, provided the Underwriters has actual knowledge of the court decree and its terms.
2. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the child's health care expenses, the Order of benefit Determination rules shall be the same as those for a *Dependent* Child who's Parents are not Divorced or Separated.
3. If the Underwriters have no knowledge of a court decree, or there is no such court decree, and the parent with custody of the child has not remarried, the Plan of the parent with custody of the child is the Primary Plan. The Plan of the parent not having custody of the child is the Secondary Plan.
4. If the Underwriters has no knowledge of a court decree, or if there is no such court decree, and the parent with custody of the child has remarried:
5. the Plan of the parent with custody of the child is the Primary Plan and pays benefits first;
 - a. then, the Plan of the stepparent pays benefits;
 - b. then, the Plan of the parent not having custody of the child pays benefits.

Dependents of Active/Inactive Employee

If a claimant is covered as the *Dependent* of an active *Employee* under one plan and as the *Dependent* of a retired or laid off *Employee* under another plan, the Plan which covers the claimant as the *Dependent* of an active *Employee* is the primary Plan. The Plan which covers the claimant as the *Dependent* of a retiree or of a laid off *Employee* is the Secondary Plan.

If the other Plan does not have a provision regarding *Dependents* of laid off or retired *Employees*, which results in each Plan determining its benefits after the other, then this rule shall not apply.

J.3. Applicability of Continuance Coverage

If a person whose coverage is provided under a right of continuation pursuant to U.S. federal or state law also is covered under another plan, the following shall be the order of benefit determination:

1. the benefits of the Plan covering the person as an *Employee* or as that *Employee's* *Dependent* will pay first; and
2. the benefits under the continuance of coverage will pay second.

If the order plan does not have this rule concerning continuation of coverage and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

If the above rules do not establish an order of Benefit Determination, the Benefits of the Plan that has covered the Claimant for the longer period of time will be the Primary Plan.

J.4. Effect of Order of Determination on the Benefits of this Plan

(This section does not apply to *Medicare*)

This section applies when, in accordance with the Order of Benefit Determination rules, this *Certificate of Insurance* is a Secondary Plan as to one or more other Plans. In that event, the benefits of this *Certificate of Insurance* may be reduced under this section.

The benefits of this *Certificate of Insurance* will be reduced when the sum of the benefits that would be payable for Allowable Expenses under this *Certificate of Insurance* in the absence of this Coordination of Benefits provision; and under the other Plans, in the absence of Coordination of Benefits or similar provisions, whether or not a claim is filed exceeds Allowable Expenses in a Claims Determination Period. In that case, the benefits of this *Certificate of Insurance* will be reduced so that they and the benefits payable under the other Plans do not exceed 100% of the Allowable Expenses. Benefits payable under all other Plans include any benefits that would have been payable had claim been properly made for them.

When the benefits of this *Certificate of Insurance* are reduced, as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this *Certificate of Insurance*.

If this *Certificate of Insurance* is the Secondary Plan, it will not deny coverage or payment of benefits payable as Secondary payer solely on the basis of the failure of the Primary Plan to pay benefits. However, in no event will this require that this *Certificate of Insurance* pay the obligations of the Primary Plan.

J.5. Effects of Medicare on the Benefits of this Plan

This *Certificate of Insurance* is the Primary Plan and *Medicare* is the Secondary Plan for:

1. an *Employee* who is covered under this *Certificate of Insurance* by virtue of his or her current employment status, age 65 or over, and eligible for Part A of *Medicare*; or

2. his or her *Dependent Spouse* who is age 65 or over and eligible for Part A of *Medicare*; Providing the *Employer* employed 20 or more *Employees* on a typical business day during the preceding policy year.

This *Certificate of Insurance* is also the Primary Plan and *Medicare* is the Secondary Plan for an *Employee* or a *Dependent*.

1. with End Stage Renal Disease (ESRD) who is within the first 21 months of renal dialysis. (The 21-month period is reduced to 18 months if the 3-month waiting period for Medicare entitlement is waived due to the Covered Person's participating in a self-dialysis training program in a Medicare-approved training facility before the third month after dialysis begins.); or
2. who is under age 65, is eligible for Medicare on the basis of a disability, as by the Social Security Administration, who is covered under this Certificate of Insurance because the Employee is currently working, and the Employee's Employer employed 100 or more Employees on a typical business day during the preceding policy year.

In all other instances, *Medicare* is the Primary Plan and this *Certificate of Insurance* is the Secondary Plan.

If a *Covered Person* who is eligible for *Medicare* chooses *Medicare* as his or her Primary coverage Plan, his or her coverage under this *Certificate of Insurance* will automatically cease.

J.6. Right to receive and release necessary information

In order to apply this provision, the Underwriters may obtain from or release to any other insurance Underwriters, organization or person any information it deems necessary.

J.7. Facility of Payment

Whenever payments that should have been made under this Certificate of Insurance have been made under any other Plan, the Underwriters have the right, alone and at its sole discretion, to pay that amount to the Plan that made the payment. Any amounts so paid will be deemed to be benefits paid under this Plan and to fully satisfy the Underwriters' liability under this provision.

J.8. Right of Recovery

If the Underwriters pays an amount greater than it should have paid due to this Coordination of Benefits provision, it has the right to recover such excess from any person to or on whose behalf it has made such payments; or any insurance Underwriters; or any other Plan, service plan or organization.

K. GENERAL PROVISIONS

K.1. Entire Contract; Changes

This *Certificate of Insurance*, the attached application, any amendments or endorsements, and the enrollment forms (if any) of the *Employees* insured, make up the entire Contract between the parties.

No change may be made to this *Certificate of Insurance* unless it is approved by an Officer of the Underwriters. A change will be valid only if made by a *Certificate of Insurance* endorsement or amendment and signed by an Officer of the Underwriters. No agent or other person may change this *Certificate of Insurance* or waive any of its provisions.

K.2. Statements of the *Employers* or *Covered Persons*

All statements made by the *Employer* or *Covered Person* will, in the absence of fraud, be considered representations and not warranties. The Underwriters will not use any such statement to contest a claim or to void coverage, unless:

1. the statement is in written form, signed by the *Employer* or *Covered Person*, as the case may be; and
2. at the time insurance is contested, a copy of the form which contains the statement is given to the *Covered Person*, or other party to the contest.

K.3. Time Limit on Certain Defenses

After this *Certificate of Insurance* has been in force for 2 years from the *Certificate of Insurance* Effective Date, no statement made by the *Employer*, except a fraudulent misstatement, shall be used to void this *Certificate of Insurance*.

After a *Covered Person's* insurance under this *Certificate of Insurance* has been in effect for 2 years, no statement made on his or her written request for insurance shall be used to reduce or deny a claim incurred after such 2-year period, except a fraudulent misstatement.

K.4. Misstatement of Facts

If it is discovered that relevant facts about a *Covered Person* have been misstated:

1. if the error has an effect on premium, an adjustment of the premiums will be made; and
2. the correct facts will determine whether and in what amount insurance is valid under this *Certificate of Insurance* for such person.

K.5. Certificates

The Underwriters will give each *Employer* certificates or booklets of Group Insurance to be given to *Employees*. The document will be evidence of insurance and will describe the main benefits, provisions and limitations of this *Certificate of Insurance* which pertain to *Covered Persons*. Certificates are not part of this *Certificate of Insurance*. In case of conflict, all rights and benefits are determined solely by this *Certificate of Insurance*.

K.6. Assignment

No assignment of any present or future right or interest under this *Certificate of Insurance* by any *Employer*, or any *Employee* or *Dependent* will bind the Underwriters.

K.7. Non-Participating

This *Certificate of Insurance* will not share in any of the Underwriters' surplus earnings. The *Employer* receives no dividends under this *Certificate of Insurance*.

K.8. New Entrants

The *Certificate of Insurance* will allow the *Employer*, from time to time, to add new eligible *Employees* or eligible *Dependents* of *Employees* in accordance with the terms of this *Certificate of Insurance*.

K.9. Insurance Data

The *Employer* agrees to give to the Underwriters such data as may be necessary for the correct implementation of this *Certificate of Insurance's* provisions and for premium and rate calculations. The records of the *Employer* will be open to the Underwriters for inspection at all reasonable times for any purpose relating to the provisions of this *Certificate of Insurance*.

K.10. Worker's Compensation not affected

The *Certificate of Insurance* does not replace and does not affect any requirement for worker's compensation insurance.

K.11. Non-Discrimination

In the administration of the *Certificate of Insurance*, the *Employer* will act so as not to discriminate unfairly between individuals in similar situations at the time of the action. The Underwriters will be entitled to rely on any such action without being obliged to inquire into the circumstances.

K.12. Clerical Error

Clerical errors or delays in keeping records for the *Certificate of Insurance* by the Underwriters, or by the *Employer*:

1. will not deny insurance which should otherwise have been granted; and
2. will not extend insurance which should otherwise have been terminated; and
3. will be subject to proper adjustment of premium when an adjustment is needed.

K.13. Fraud

The Underwriters may terminate an *Employee's* and his or her *Dependents'* coverage by giving written notice to the *Employee* for misrepresentation on the enrollment application or for fraud in obtaining coverage. Termination is effective as of the effective date of the *Employee's* coverage under this *Certificate of Insurance*. The Underwriters will refund all premiums paid on behalf of the *Employee* less benefit payments paid to or on behalf of the *Employee* and his or her *Dependents*. If the value of the benefits paid exceeds the amount of premiums paid, the *Employee* will pay the Underwriters an amount equal to such excess.

K.14. Payment of Premiums

Premiums due under this *Certificate of Insurance* are to be paid on or before each due date in U.S. dollars, unless an alternate currency is approved, in writing, by the Underwriters. Premium due dates, with respect to the *Employer* are stated on the face page of this *Certificate of Insurance*. The *Employer* may ask the Underwriters, in writing, to change the premium due date for future premiums due under this *Certificate of Insurance*. If the Underwriters approves the change, the Underwriters will make such change on the *Certificate of Insurance* Anniversary Date on or next after the request.

With respect to *Employers*, premiums are to be paid in U.S. dollars (unless an alternate currency is approved, in writing, by the Underwriters) by each *Employer* for its share of total premium due under this *Certificate of Insurance*. Premiums are to be paid by each *Employer* on or before such *Employer's* premium due date.

K.15. Grace Period

A grace period of 31 days, without interest charge, will be allowed for payment of any premium due after the first premium. During this time an *Employer's* participation under this *Certificate of Insurance* will stay in force unless, as of the prior premium due date:

1. the Underwriters has been given written notice by the *Employer* to terminate its participation under this *Certificate of Insurance*; or
2. the Underwriters has been given written notice by the *Employer* to terminate this *Certificate of Insurance*.

If premium due is not paid within the grace period, the Underwriters will terminate the *Employer's* participation under this *Certificate of Insurance* at the end of the grace period. The Employer must pay all due and unpaid premiums, including premium for the grace period.

If the Underwriters is given written notice by an *Employer* during the grace period to terminate its coverage under this *Certificate of Insurance*, the Underwriters will terminate its coverage on the later of:

1. the date requested by the Employer; or
2. the date the Underwriters receives the notice.

The Employer must pay all unpaid premium through the date of termination.

K.16. Premium and Premium Rate Change

Premium for each *Covered Person* shall be as announced by the Underwriters, to take affect on the date stipulated, and periodic premium due from the *Employer* will be calculated based on these rates multiplied by the number of *Covered Persons*. The monthly rates for adult *Covered Persons* resident in the United States (including Puerto Rico) and Canada, with the exception of dependent children who are eligible as students, will be 2.07 times the monthly rates applicable to adult resident elsewhere.

The Underwriters has the right to change any premium, or rate basis, on:

1. any premium due date. The Underwriters must notify the Employer at least 31 days before the Underwriters makes the change; or
2. any date the terms of this Certificate of Insurance or an Employer's group insurance plan are changed, if such changes have an impact on the rates.

K.17. Other Premium Changes

Premium changes due to the following will occur automatically and will be charged from the date the change occurs:

1. an increase or decrease in benefits; or
2. additions, deletions, increases or decreases of an Employee's Dependents insurance; or
3. addition of a new Employee; or
4. termination of an Employee; or
5. the Employer's relocation to a different geographical area.

Any such change will be prorated to the premium payment period of the *Employer* and reflected on the *Employer's* next billing statement.

Premium changes because of an *Employee's* or *Dependent's* change in age will occur automatically, and will be charged from the beginning of the premium month on or next following the change in age.

If the Underwriters has been paid unearned premium due to an error, administrative delay, or any other cause, the Underwriters will return such premium when the error is discovered. The Underwriters will not, however, be required to return any premium paid to the Underwriters more than 12 months from the date such error is discovered.

K.18. Termination of *Certificate of Insurance*

The *Employer* has the right to terminate this *Certificate of Insurance* on any premium due date. Written notice of such termination must be given to the Underwriters at least 31 days before the date this *Certificate of Insurance* is to end. The Underwriters has the right to terminate this *Certificate of Insurance* on any *Certificate of Insurance* Expiration date. The Underwriters must give written notice to the *Employer* at least 31 days before terminating this *Certificate of Insurance*.

The *Employer's* coverage under this *Certificate of Insurance* will automatically terminate on the earliest of the following dates:

1. the date it discontinues or suspends active business operations;
2. the date it no longer exists because of dissolution, merger, bankruptcy, insolvency or otherwise; or
3. the due date of any required premium payment that is due and unpaid at the end of the Grace Period.

With respect to coverage of *Employees* of the *Employer*, termination will not become effective during any period for which a premium has been paid to the Underwriters for such coverage.

An *Employer's* coverage under this *Certificate of Insurance* will automatically terminate on the date the coverage under this *Certificate of Insurance* terminates.

K.19. *Certificate of Insurance* Renewal on its Expiration Date

This *Certificate of Insurance* is automatically renewed on each *Certificate of Insurance* Expiration Date unless it is terminated by the Underwriters, as stated under the Termination of *Certificate of Insurance* provision.

K.20. Notice of Claim

For claims that do not require precertification, notice of claim must be given to the Underwriters within 180 days after a covered loss occurs or as soon after the loss as reasonably possible. The Underwriters will not deny or reduce a claim if it is shown not to have been reasonably possible to give written notice and that notice was given as soon as was reasonably possible.

Notice should include the *Covered Person's* name, certificate number, the name of the insured person for whom the claim is being made, and the nature and extend of the loss.

K.21. Claim Forms

When the Underwriters receive the notice of claim, the forms for filing Proof of Loss will be sent to the *Covered Person*. If these forms are not sent within 15 days, the claimant may comply with the requirements for furnishing Proof of Loss by submitting written proof within the time permitted in this *Certificate of Insurance* for filing such Proof of Loss. Such written proof must cover the occurrence, the nature and the extent of loss.

K.22. Proof of Loss

Written Proof of Loss must be given to the Underwriters within 180 days after the date of the loss. Proof of Loss must cover the occurrence, character, and extent of the loss.

The Underwriters will not reduce or deny a claim when the *Covered Person* fails to furnish Proof of Loss within 180 days of the loss if he or she shows that it was not reasonably possible to furnish such proof within the time allowed, and if he or she submits the proof as soon as reasonably possible. The

Underwriters will not accept any Proof of Loss, except in the absence of the *Covered Person's* legal capacity, after one year from the time it was otherwise required.

K.23. Payment of Benefits

Within 45 days of the Underwriters' receipt of Proof of Loss, the Underwriters will:

1. pay the benefits due under the *Certificate of Insurance*; or
2. notify the *Covered Person*, in writing, of the reasons for nonpayment of the claim; or
3. notify the *Covered Person*, in writing, that additional documentation is necessary for the review and/or payment of the claim within the terms of the *Certificate of Insurance*.

All benefits will be payable to the *Employee*. However, the *Employee* may request, in writing and no later than the time Proof of Loss is filed, that the Underwriters pay any part or all of any benefits provided due to *Hospital, Extended Care Facility*, nursing, medical, or surgical services directly to the facility or person providing the services.

K.24. Facility of Payment

If a *Covered Person* is not legally capable of giving a valid receipt for payment of benefits, the Underwriters reserves the right to make payment to the party it determines to be so entitled, if there is no legal guardian. Payment made in good faith under this provision will fully discharge the Underwriters' obligation to the extent of such payment.

K.25. Physical Examinations

While a claim is pending, the Underwriters have the right and opportunity to have any claimant examined, without expense to the claimant, when and as often as it may reasonably require. The Underwriters also has the right, at its own expense, to conduct or have conducted appropriate investigations relative to a *Covered Person's* death, or to request an autopsy to be done after death, where it is not prohibited by law.

K.26. Denial of Claims

The Underwriters will notify the *Covered Person* if a claim for benefits is denied, in whole or in part. Such notice shall be in writing, and it shall include the specific reason for the denial.

K.27. Claims Appeal Procedure

The Underwriters will provide a written explanation of the reason it denies, in whole or in part, a claim for benefits under this *Certificate of Insurance*. If there is any question about the settlement or denial of a claim, a *Covered Person* has the right to request a full and fair review of that claim.

The process is as follows:

1. Within 90 days of receiving a claim denial, a certified letter must be sent to the Underwriters stating the reasons for appeal and any additional information to support the claim.
2. To help the Underwriters identify and process the appeal, the Covered Person must include either a photocopy of the Underwriters' letter of denial or clearly identify his or her Certificate number, the person for whom claim was made, the provider and amount of the claim, the date claim was made, and the date it was denied.
3. After the Underwriters' review of the written information, the Covered Person or his or her representative may give further written or verbal support to the claim and review any pertinent documents.

4. Within 60 days of the written appeal, the Underwriters will notify the Covered Person by mail of the final decision and the specific reason for the decision. If more extensive review is required, a final decision will be made within 120 days from the date of appeal.

K.28. Right of Recovery

The Underwriters has the right to recover amounts overpaid to, or on behalf of, a *Covered Person* as benefits under this *Certificate of Insurance*.

In the event a *Covered Person* is entitled to payment or reimbursement from any other person or organization as a result of a legal action or claim that is due to an *Injury* or *Illness* or to Worker's Compensation for which benefits have been paid under this *Certificate of Insurance*, the Underwriters shall have the right to have a lien on the proceeds of any recovery from such person or organization, whether by judgment, settlement, or otherwise, but not to exceed the lesser of: a) the total amount of such benefits paid for the *Injury* or *Illness*; and b) the amount actually recovered by the *Covered Person*, less legal fees and costs paid from that amount to pursue the recovery. The Underwriters' recovery under this provision will be limited to the amount paid by the third party, or that party's insurer, that exceeds the *Covered Person's* total loss, i.e., after the *Covered Person* has been made whole for the total loss sustained.

The *Covered Person* shall take no action to prejudice the Underwriters' right of recovery and shall execute and furnish such papers or other Information as the Underwriters may require.

K.29. Subrogation

If a *Covered Person* is injured through the act or omission of a third party, to the extent the *Covered Person* collects benefits under this *Certificate of Insurance* for the diagnosis, care, or treatment of the *Injury*, the Underwriters may be subrogated to the *Covered Person's* rights against the third party to the extent of the benefits paid plus reasonable costs of collection. The *Covered Person* shall promptly inform the Underwriters of any situation or circumstance which may allow the Underwriters to invoke its right under this Provision.

The *Covered Person* shall cooperate with the Underwriters in assisting to protect its legal rights under this subrogation provision. The *Covered Person* shall do nothing to prejudice the Underwriters' rights under this provision, either before or after the need for benefits under this *Certificate of Insurance* has elapsed.

K.30. Legal Actions

No action at law or in equity shall be brought to recover on the *Certificate of Insurance* until 60 days after the required written Proof of Loss has been furnished. No such action shall be brought more than 3 years after the time written Proof of Loss is required to be furnished.

K. 31. Covered Person/ Provider Relationship

The choice of a Provider or choice of treatment by a Provider is solely that of the Covered Person. The group health benefits plan does not furnish Covered Services but only makes payment for Covered Services received by a Covered Person. The group health benefits plan is not liable for any act or omission of any Provider. The group health benefits plan has no responsibility for a Provider's failure or refusal to render Covered Services to a Covered Person.

K. 32 SERVICE OF SUIT CLAUSE (U.S.A.)

It is agreed that in the event of the failure of the Underwriters hereon to pay any amount claimed to be due hereunder, the Underwriters hereon, at the request of the Insured (or Reinsured), will submit to the jurisdiction of a Court of competent jurisdiction within the United States. Nothing in this Clause constitutes or should be understood to constitute a waiver of Underwriters' rights to commence an action

in any Court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another Court as permitted by the laws of the United States or of any State in the United States.

It is further agreed that service of process in such suit may be made upon **MENDES & MOUNT, 750 7th Avenue, New York, NY 10019 USA** and that in any suit instituted against any one of them upon this contract, Underwriters will abide by the final decision of such Court or of any Appellate Court in the event of an appeal.

The above-named are authorized and directed to accept service of process on behalf of Underwriters in any such suit and/or upon the request of the Insured (or Reinsured) to give a written undertaking to the Insured (or Reinsured) that they will enter a general appearance upon Underwriters' behalf in the event such a suit shall be instituted.

Further, pursuant to any statute of any state, territory or district of the United States which makes provision therefor, Underwriters hereon hereby designate the Superintendent, Commissioner or Director of Insurance or other officer specified for that purpose in the statute, or his successor or successors in office, as their true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the Insured (or Reinsured) or any beneficiary hereunder arising out of this contract of insurance (or reinsurance), and hereby designate the above-named as the person to whom the said officer is authorized to mail such process or a true copy thereof.

K. 33. APPLICABLE LAW (U.S.A.)

This Insurance shall be subject to the applicable state law to be determined by the court of competent jurisdiction as determined by the provisions of the section **K. 32 SERVICE OF SUIT CLAUSE (U.S.A.)**.

K. 34. SEVERAL LIABILITY NOTICE

The subscribing insurers' obligations under contracts of insurance to which they subscribe are several and not joint and are limited solely to the extent of their individual subscriptions. The subscribing insurers are not responsible for the subscription of any co-subscribing insurer who for any reason does not satisfy all or part of its obligations.

K. 35. Complaints Procedure

We are dedicated to providing You with a high quality service and We want to ensure that We maintain this at all times. If You feel We have not offered You a first class service please write and tell Us and We will do Our best to resolve the problem.

All complaints shall be handled promptly and a Certificate of Insurance of open communication will be adopted.

Any enquiry or complaint should in the first instance be directed through Your insurance broker or other intermediary who arranged this Insurance for You to the Manager of Our local office. If this does not resolve the matter please write to:

Lloyd's Market Services
G6/86
One Lime Street
London

EC3M 7HA

Email: complaints@lloyds.com

Tel: +44 (0)20 7327 5693

Fax: +44 (0)20 7327 5225

In the event *You* remain dissatisfied and wish to pursue matters further *You* may be able to refer the matter to The Financial Ombudsman Service. The Financial Ombudsman Service can normally deal with complaints from private individuals and from small businesses with an annual turnover of less than £1 million (for a group of companies, this means a group annual turnover of less than £1 million). The Financial Ombudsman Service can also help with complaints from charities with an annual income of less than £1 million and from trusts with a net asset value of less than £1 million.

The address is:

The Financial Ombudsman Service

South Quay Plaza

183 Marsh Wall

London

E14 9SR

Helpline: 0845 080 1800

Switchboard: 020 7964 1000

Website: www.financial-ombudsman.org.uk

Financial Services Compensation Scheme

We are covered by the Financial Services Compensation Scheme (FSCS). *You* may be entitled to compensation from the scheme if *We* cannot meet *Our* financial obligations. This depends on the type of business and the circumstances of the claim. Further information about compensation scheme arrangements is available from the FSCS.

Financial Services Compensation Scheme

7th floor Lloyds Chambers

Portsoken Street

London E1 8BN

Fax: 020 7892 7301

Endorsement for Dental Benefits

This endorsement is to be attached to and form part of the Certificate for
Korea International School
Effective Date: August 1, 2010

Dental Schedule of Benefits

Individual Deductible (waived for Class I)	\$25.00
Family Deductible	\$75.00
Maximum Benefit - Classes I, II, III, IV combined	\$1,000.00 per year

Dental Insurance Benefits

The individual Dental deductible stated in the schedule must be satisfied for each calendar year before benefits for Class II, III and IV are payable.

After Dental deductibles equaling the family deductible have been applied in a calendar year for either, a.) the employee and dependents; or b.) the dependents, the family need not satisfy any further Dental deductible for the rest of that year.

1. Benefits Payable

Class I	Plan pays 100% of expenses for preventive care, without a deductible.
Class II	Plan pays 80% of expenses for basic restorative care, the deductible applies.
Class III applies.	Plan pays 50% of expenses for major restorative services, the deductible applies.
Class IV applies.	Plan pays 50% of expenses for orthodontic dental services, the deductible applies.

If the Employee or a Dependent incurs covered dental expenses, the Underwriters will:

- a. deduct any dental deductible that applies from the covered dental expenses first incurred in a calendar year for a person; and
- b. pay for the other covered dental expenses incurred in that calendar year up to the Maximum Benefit, subject to the Alternate Benefit Provision.

The dental deductibles apply to the Classes of care shown above.

2. Benefit Waiting Period

If an Employee does not enroll for Dental Benefits for himself and/or his Eligible Dependents when first eligible, no benefits will be payable for Class III or Class IV dental services until he or she and/or his or her Dependents have been covered for Dental Benefits for a period of 24 consecutive months.

3. Missing Teeth Limit

The amount payable for first replacement of teeth that are missing when a person becomes insured is 50% of the amount otherwise payable for these benefits. After a person has been continuously insured for 24 months, this limit will no longer apply.

4. Alternate Benefit Provision

When more than one dental service could provide suitable treatment based on common dental standards, the Underwriters will determine the dental service on which payment will be based and the expenses that will be included as covered dental expenses. Benefits will be provided for treatment rendered in accordance with accepted dental standards for adequate and appropriate care. The Employee and his or her Dentist are free to apply this benefit to the treatment chosen; the Employee, however, will be responsible for the expenses incurred which exceed covered dental expenses.

5. Covered Dental Expenses

The term covered dental expenses means expenses incurred by or on behalf of the Employee or a Dependent for charges made by a Dentist for the performance of a dental service listed in the dental services schedule.

Covered dental expenses will include only those expenses incurred for such charges when the dental service:

- a. is for the classes of covered dental services described in this section of the Certificate, as shown in the Schedule of Dental Benefits; and
- b. is performed by or under the direction of a Dentist or Physician;
- c. is essential for the necessary care of teeth; and
- d. is not in excess of the charges for any less expensive alternate procedure (as described under the Alternate Benefit provision); and
- e. is not in excess of the reasonable and customary charges for the service, treatment or supplies furnished;
- f. starts and is completed while the person is insured.

A covered dental expense is deemed to start when the actual performance of the service starts except that;

- a. For fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
- b. For a crown, inlay or on lay, it starts on the first date of preparation of the tooth involved.
- c. For root canal therapy, it starts when the pulp chamber of the tooth is opened.

A temporary dental service is included in the allowance for the first dental service and is not a separate dental service.

Covered dental expenses will include expenses incurred for dental services listed above. The Underwriters may agree to accept, as covered dental services not listed. To be considered, services should be identified in terms of the *American Dental Association Uniform Code on Dental Procedures and Nomenclature* and/or by description and submitted to the Underwriters.

7. Predetermination of Benefits

The term predetermination of benefits means a review by the Underwriters of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information

should be sent to the Underwriters before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to the Underwriters.

The expenses that will be included as covered dental expenses will be determined by the Underwriters and are subject to the Alternate Benefit provision. When there has not been a predetermination of benefits, the Underwriters will determine the expenses that will be included as covered dental expenses at the time the claim is received.

Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Course of treatment means the plan of treatment for a specific dental condition, as recommended by the Dentist or Physician, which is based upon a diagnosis established by an initial examination; including, but not limited to, the following diagnostic procedures:

- a. Panoramic radiograph or full-mouth set of x-rays, and bitewing x-rays;
- b. Other specialized films (such as sialography, TMJ films, cephalometric films, and postero-antero films) taken at the Dentist's or Physician's discretion based on the Covered persons symptoms;
- c. Study models;
- d. Pulp vitality tests;
- e. Bacteriological culture for determination of pathological agents;
- f. Pocket depth charts; and
- g. Other tests and laboratory examinations which may be required to establish a diagnosis and treatment plan.

8. Class I Services – Diagnostic and Preventive

The maximum covered dental expense for any Class I Service is the reasonable and customary charge.

- a. Clinical oral examination –Two (2) per person per calendar year.
 1. Palliative (emergency) treatment of dental pain, minor procedures, when no other definitive dental services are performed (any x-ray taken in connection with such treatment is a separate dental service).
 2. X-rays – Complete series- Only one (1) per person, including panoramic film (Panorex), in any 3 calendar years.
 3. Bitewing X-rays – Only two (2) charges per person per calendar year.
 4. Prophylaxis (Cleaning) – Only two (2) per person per calendar year.
 5. Periodontal maintenance procedures (following active therapy), Periodontal Prophylaxis.
- b. Topical application of fluoride (excluding Prophylaxis) –Limited to persons less than 19 years old. Only one (1) per person per calendar year.
- c. Topical application of sealant, per tooth, on posterior tooth for a person less than 14 years old – Only one (1) per person per calendar year.
- d. Space Maintainers, fixed unilateral –Limited to non-orthodontic treatment.

9. Class II Services – Basic Restorations, Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery

The maximum covered expense for any Class II service is 80% of reasonable and customary charges for the following:

- a. Amalgam Filling –Primary (Baby) Teeth – One (1) surface.
- b. Amalgam Filling –Permanent Teeth –One (1) surface.
- c. Composite/Resin Filling – One (1) surface.
- d. Root Canal Therapy – Any X-ray, test, laboratory exam or follow-up care is part of the allowance for root canal therapy and not a separate dental service.
- e. Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate dental service.
- f. Periodontal Scaling and Root Planning – Entire Mouth. If more than one periodontal surgical service is performed per quadrant, only the one with the largest maximum covered expense is a dental service.
- g. Adjustments – Complete Denture. Any adjustment of or repair to denture within 6 months of its installation is not a separate dental service.
- h. Replacement Bridge
- i. Simple Extractions
- j. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth.
- k. Removal of Impacted Tooth, Soft Tissue
- l. Removal of Impacted Tooth, Partially Bony
- m. Removal of Impacted Tooth, Completely Bony

Local anesthetic, analgesic and routine post-operative care for extractions and other oral surgery are part of the allowance for each dental service.

General Anesthesia – The administration of a general anesthesia is a covered dental service only;

- a. when medically necessary in conjunction with oral or dental surgery; and
- b. if the anesthetic agent produces a state of unconsciousness with the absence of pain sensation over the whole body.

10. Class III Services – Major Restorations, Dentures and Bridgework

The maximum covered dental expense for any Class III service is 50% of the reasonable and customary charge for the following:

- a. High noble metal (gold) or crown restorations are dental services only when the tooth, as a result of extensive caries or fractures, cannot be restored with amalgam, composite/resin, silicate, acrylic or plastic restoration.
- b. Crown
- c. Porcelain Fused to High Noble Metal
- d. Full cast, High Noble Metal
- e. Three Fourth Cast, Metallic
- f. Fixed or Removable appliances

- g. Complete (Full) Dentures, Upper or Lower
- h. Partial Dentures
- i. Lower, Cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- j. Upper, Cast metal base with resin saddles (including any conventional clasps, rests and teeth)
- k. Bridge Pontics – Cast high noble metal
- l. Bridge Pontics – Porcelain with high noble metal
- m. Bridge Pontics - Resin with high noble metal
- n. Abutment Crowns - Resin with high noble metal
- o. Abutment Crowns - Porcelain with high noble metal
- p. Abutment Crowns– Full cast high noble metal

11. Class IV Services – Orthodontic Dental Services

The maximum covered dental expense for Class IV Services service is 50% of the reasonable and customary charge for the following:

- a. Examination and diagnosis, including cephalometric x-rays and treatment planning
- b. Diagnostic casts (study models) for orthodontic evaluations
- c. Surgical exposure of an impacted tooth unerupted for orthodontic purposes
- d. Extractions performed for orthodontic purposes; and
- e. Fixed or removable orthodontic appliances for tooth movement and/or tooth guidance.

Benefits for Orthodontic Treatment are payable only for Covered Persons only if such treatment starts after such Covered Person's effective date of coverage for Class IV covered dental expenses under the Certificate, and satisfaction of the applicable Benefit Waiting Period.

Benefits will be paid in equal quarterly installments over the course of the entire treatment plan, starting on the date the orthodontic appliances are first placed.

- a. Benefits end when the active Orthodontic treatment ends or the maximum benefit for Class IV covered dental expenses is reached, whichever comes first.

If coverage for Dental Benefits, or Class IV covered dental expenses, terminates, benefits will be paid only to the end of the third month in which the insurance ends, and only for expenses incurred while insurance was in force.

The Underwriters have the right to require the following information to determine what benefits the Underwriters will pay: full mouth dental x-rays; cephalometric x-rays and analysis; study models; and completion of a questionnaire concerning; the degree of overjet, overbite, crowding or open bite; whether teeth are impacted, in cross bite or congenitally missing; the expected length of treatment and the total charge for treatment.

Orthodontic treatment means the corrective movement of the teeth through the alveolar bone by means of an active appliance to correct a diagnosed malocclusion of the teeth. Treatment is deemed to start on the day the bands or appliances are inserted or on the date a one-step orthodontic procedure is performed.

Exclusions for Dental Benefits

No benefits will be paid under these Dental Benefits for;

1. costs that are not covered dental expenses, (as defined); or for procedures that are not included in the Classes of covered dental expenses which are not included in the Certificate, as shown in the Schedule of Dental Benefits;
2. procedures that are not medically necessary, or which are not considered to be safe or effective, or are considered to be Experimental or Investigative;
3. any portion of a charge in excess of the reasonable and customary charge;
4. appliances, crowns, inlays, cast restorations, onlays, or laboratory-prepared restorations used primarily for the purpose of splinting;
5. a procedure, service, or supply which may not reasonably be expected to successfully correct a Covered Person's dental condition for a period of at least three years;
6. any procedure, service, supply, or appliance for the sole or primary purpose of which relates to:
 - a. the change or maintenance of vertical dimension;
 - b. the restoration or alteration of occlusion, except for occlusal adjustment in conjunction with periodontal surgery;
 - c. bite registration; or
 - d. bite analysis;
7. cosmetic procedures, services, supplies or appliances (including facings on crowns or bridge units on molar teeth and personalization of dentures);
Cosmetic means surgery or other treatment to improve a person's appearance.
8. the initial placement of a full or partial denture unless it includes the replacement of functioning natural tooth extracted while insured under for Dental Benefits under the Certificate, and placement occurs within 24 months after the extraction;
9. the initial placement of a fixed bridge (including a Maryland bridge) unless it includes the replacement of functioning natural tooth extracted while insured for Dental Benefits under the Certificate, and placement occurs within 24 months after the extraction (limited to no more than once in 5 years for a Maryland bridge);
10. the replacement of all or partial denture or a fixed bridge (including Maryland bridge), or the addition of teeth to a partial denture unless;
 - a. the denture or bridge to be replaced was a covered benefit under the Certificate, and the replacement or addition of teeth occurs at least 5 years after placement of an existing denture or Maryland bridge, and at least 7 years after the placement of a conventional bridge; or
 - b. replacement or addition of a tooth to a partial denture is due to the extraction of a functioning natural tooth while insured, and placement occurs within 24 months after the extraction; or
 - c. replacement is due to an injury (including a chewing injury) to sound natural teeth and is accomplished within 12 months of the injury.

Sound natural teeth means any teeth or parts of the teeth that are organic and formed by natural development of the body (not manufactured) which are functional, or restored to function, do not have any decay, are not more susceptible to injury than virgin teeth, and are without significant periodontal disease.

11. the replacement of crowns, cast restorations, inlays, onlays, or other laboratory-prepared restoration within 5 years of the date of placement;
12. the replacement of a bridge, full or partial denture, crown, cast restoration, inlay, onlay or other laboratory-prepared restoration that can be repaired and restored to function;
13. the replacement of an existing partial denture with fixed bridgework unless it is essential to the correction of the Covered Person's dental condition;
14. replacement of teeth beyond the normal compliment of 32;
15. implants or insertion of implants and/or related appliances (except to the extent payable under the Alternate Benefit provision) or the surgical removal of implants;
16. the replacement of lost or stolen appliances; the replacement of orthodontic retainers; myofunctional therapy; athletic mouth guards; precision or semi-precision attachments; or denture duplication;
17. the treatment of fractures; infection control; orthognathic surgery;
18. treatment or diagnosis of a muscular, neural, or skeletal disorder; dysfunction; or disease of the temporomandibular joints or their associated structure;
19. travel time, transportation costs, or professional advice given on the telephone;
20. oral hygiene instruction; acid etch; the completion of a claim form, broken appointments, exams required by a third party; or personal supplies (water pik, toothbrush, floss holder, etc.);
21. any medical or hospital care charge and related anesthesia charges;
22. procedures that are begun but not completed;
23. charges that are applied toward satisfaction of a deductible;
24. any dental procedures or services for which benefits are payable under any medical plan provided by the Employer or which are provided through a medical or dental department or clinic maintained by the Employer or a related organization;
25. procedures or services for which there would be no charge in the absence of insurance or for treatment provided without charge;
26. treatment that results from war or an act of war, whether declared or undeclared, or condition contracted or accident occurring while on full-time active duty in the armed forces of any country;
27. expenses due to an injury or illness that is covered under Worker's Compensation Law, Occupational Disease Law, or similar laws, whether or not such benefits have been applied or paid;
28. treatment which results from voluntary participation in an assault, felony, insurrection or riot;
29. charges by any provider of care or service who is not properly licensed or approved as required;
30. treatment due to intentional self-inflicted injury; or

31. treatment which is rendered by a person who ordinarily resides in the Covered Person's home or is a member of the family (father, mother, brother, sister or child) of the Employee or his/her spouse.

Extension of Dental Benefits

If a *Covered Person* is undergoing a course of treatment on the date his or her coverage under this *Certificate* would otherwise terminate, Dental Benefits will continue to be payable as if insurance had not stopped (without premium payment) but only for that dental condition to which such course of treatment applies at the time dental insurance stops. Coverage will continue until the earliest of:

1. the date the course of treatment end; or
2. the end of the 30-day period of time which on the date dental insurance stops; or
3. the date the Employer replaces this Dental insurance with another plan of dental insurance.

For certain Classes of covered dental expenses, a course of treatment will be considered completed as follows:

1. for root canal therapy, on the date the canals are permanently filled;
2. for bridges (including Maryland bridges), crowns, inlays, onlays, and other laboratory-prepared restorations, on the date the appliance is permanently cemented in place; or
3. for dentures or partial dentures, on the date the final completed appliance is first inserted in the mouth; however, no denture or partial denture will be considered completed until it is accepted by the patient.

Endorsement for Vision Care Benefits

This endorsement is to be attached to and form part of the Certificate for
Korea International School
Effective Date: August 1, 2010

Vision Care Schedule of Benefits

100% of Reasonable and Customary Charges
Up to \$150 for a routine eye examination every 24 months
Up to \$100 for corrective lens every 24 months
Not subject to the deductible and coinsurance

Vision Care Benefits

1. Payment of Benefits

Subject to the exclusions which follow in Section G, the Underwriters will pay the Vision Care Benefits each year in connection with covered vision care charges the Employee or Dependent incurs while insured. The benefits payable for each type of Vision Care charges will be the percentage payable subject to the maximum limits shown in the Schedule.

Covered Vision Care Charges means those costs incurred by the Employee or Dependent for necessary vision examination, lenses and frames which are:

- a. Medically necessary under accepted standards of optical practice as essential for necessary treatment of the insured person's eye condition;
- b. Performed or ordered by an ophthalmologist or optometrist acting within the scope of his or her license, or by an optician; and
- c. Billed by the ophthalmologist, optometrist or optician who provided service, treatment or supply; and
- d. Not in excess of the reasonable and customary charge for the service, treatment or supply furnished.

2. Maximum Payment Limits

The maximum payment limits for each type of covered Vision care charge are shown in the Schedule. These are the maximum amounts that will be paid each two years.

Types of Vision Care Charges

The types of Vision Care expenses are:

Type I: An eye examination includes the complete case history, a comprehensive analysis of visual functions, the prescription of lenses where indicated, and verification and fitting of such lenses prescribed.

Type II: Consists of Charges for:

- a. Single vision, bifocal, trifocal or aphakic lenses, or contact lenses, but only if the lenses are prescribed as a result of an eye examination made while insured under this plan. The date on which the lenses are ordered shall be considered to be the date on which charges occurred and the lenses are furnished.

- b. Frames, if the frame is to be used with lenses prescribed as result of an eye examination which was made by a qualified provider while insured under this plan. The date on which the frame is ordered shall be considered the date on which the charge is occurred and the frame is furnished.

Exclusions for Vision Care Benefits

No Vision Care Benefits will be paid for:

1. charges that are not for covered Vision Care benefits or the procedures, services or supplies that are not specifically included as a Vision Care charge;
2. any portion of a charge in excess of the reasonable and customary charge;
3. services or supplies which were furnished or rendered or for which charges were incurred prior to the effective date of the Vision care benefits under the plan, or after Vision care benefits terminate;
4. orthoptics or vision training , sub-normal vision aids, aniseikonia lenses, coated lenses or any other special purpose vision aids;
5. frames to be used with lenses that do not require a prescription;
6. duplicate lenses or contact lenses, or duplicate frames;
7. repair or replacement of broken, lost or stolen lenses, contact lenses or frames;
8. medical or surgical treatment for eyes, or for any prescribed drug or other medication;
9. any procedure, service or supply which is payable under any medical expense benefit plan, or provided through a medical department or maintained by the Employer or related organization;
10. services or supplies which are furnished or rendered in connection with an illness, injury, disease or condition contracted or resulting from an act of war, declared or undeclared, civil disobedience, participation in a criminal act, riot or nuclear or atomic explosion or accident;

This additional coverage is subject to all conditions of this Certificate which it does not specifically modify.